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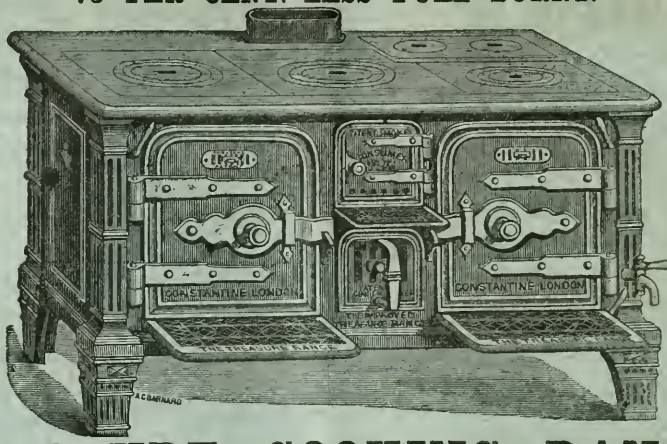

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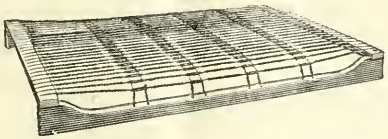

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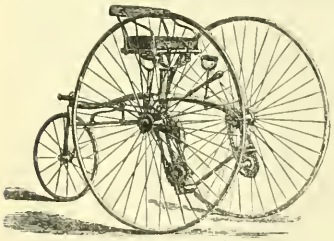

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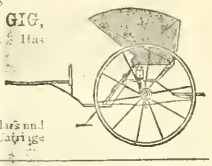

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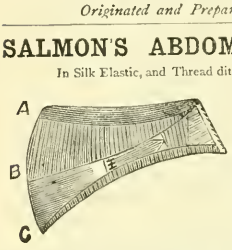

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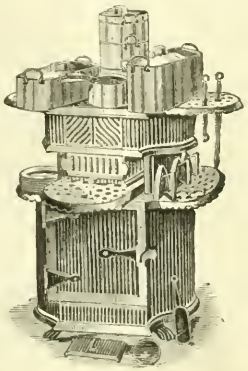

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"New York Medical Journal," *August* 1880, Dr. F. Weir,
in Lecture delivered to the College of Physicians and Surgeons, New York.

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RECKLINGHAUSEN ON THE METHOD OF FORMATION OF RANULA.

Some writers, especially Virchow, have expressed the opinion that the contents of ranulæ are secreted by the cyst-wall. In certain cases, this fact cannot be contradicted; principally when the wall has undergone pathological transformation in consequence of irritation. In mucous cysts, Professor Recklinghausen disputes this method of production. The wall of the cyst does not present cup-like cells, such as are found in the organs which secrete mucus; neither is any vitreous swelling of the protoplasm of the epithelial cells observed. Moreover, the cysts, whose walls secrete the contents, like the cysts of the gall-bladder, and of the vermiform appendix, are much smaller in relation to the normal volume of the dilated canal than mucous cysts are. The quantity of fluid secreted should be in proportion to the secreting surface; as a portion of an excretory canal has only a surface infinitely small in comparison to that of the glandular parenchyma, the fluid should certainly be formed almost exclusively in the gland at the outset of the retention. The cyst must therefore be formed by a process analogous to the dilatation of the ureter in hydronephrosis, and not to dropsy of the gall-bladder.

The physical properties of the mucus have a very important influence on the formation of ranula and of other mucous cysts. This substance has a great tendency to swell; it is extremely tenacious, and adheres a little to the walls of the canal. If we now suppose that the gland and its excretory ducts are normal, and that by some influence the secretion suddenly becomes more active, although the ducts are perfectly permeable; in this case, dilatations may be observed in their course, for the fluid secreted cannot flow with sufficient rapidity, and the mucus which flows away is less abundant than the mucus produced.

It is possible that these retentions of fluid already constitute a predisposition to chronic inflammation. Similar inflammations are somewhat frequent in muciparous glands; they affect especially the excretory ducts, and have the characteristics of interstitial inflammation. In a case observed by Professor von Recklinghausen, both of Blandin and Nuhn's glands showed anomalies; on the right side there were only dilatations of the excretory ducts, whilst on the left side there were found changes in them. Their epithelium was raised by an exudation and pushed towards the centre of the ducts; at certain points the epithelial surfaces touched, and thus produced a complete obliteration of the duct. In cases of this kind the exudation is hyaline; the whole pathological processes might, therefore, be designated, 'hyaline myxangitis'.

In addition to this form, a fibrous myxangitis is observed, in which the walls of the excretory ducts are exhausted in consequence of a new formation of connective tissue. In the latter form, the chronic inflammation is rather primary than secondary. This inflammation may determine the formation of a cyst; for this, it is enough that the proliferation of the connective tissue succeeds in obliterating the excretory duct in some point of its course. The size of the cyst depends upon the position of the stricture.

The initial dilatation always occurs in the excretory ducts or their branches; their walls, are, in fact, more extensible than the glandular *culs-de-sac*, because they are thinner and surrounded by loose connective tissue. In one of the cases observed by Professor von Recklinghausen, it is true that there was mucus in the glandular *culs-de-sac*, but, in this case there was mucous degeneration of the parenchyma, a process which cannot originate a cyst. In fact, for the formation of the latter, it is necessary that there should exist glandular lobules capable of secreting, a condition which is absolutely wanting when the parenchyma itself of the gland is in a state of degeneration.

It now remains to discuss what is the method of formation of the wall of the cyst. There is certainly a disproportion between the quantity of preformed substance which constitutes the necessary excretory duct, and the quantity of tissue necessary for the formation of the wall of a cyst, sometimes a millimètre thick. In consideration of this fact, Professor von Recklinghausen admits that the wall of the cyst is constituted partly by the surrounding tissues, and partly by a new formation. The elastic fibres, the nerves, and the striated muscular fibres, which have been found in the walls of a ranula, may be considered as elements preformed and borrowed from the neighbouring tissues; these elements, in fact, are not often met with in inflammatory neoplasms. A large part of the connective tissue and of the epithelium may be considered as newly formed. At several points of the parietes there is found a connective tissue, which is soft, loose, rich in round and fusiform cells, and very vascular. The double layer of epithelial cells, and the masses formed of from six to eight of these cells, indicate in a clear manner that the epithelium is in process of proliferation.

According to Dr. von Recklinghausen, mucous cysts have an inflammatory origin; the primary cause of all the processes is myxangitis. The proofs that this chronic inflammation is the true cause of the obliteration of the excretory ducts, have been recognised with certainty in cysts of Bartholin's gland, and in the vibratile-celled cysts of the liver. As to ranula, the writer has not been able to find any trace of obliterated excretory ducts; he has never even observed cicatrices on the lower surface of the tongue. It might be supposed that the cyst is developed as the consequence of congenital imperforation of an excretory duct; but this is no more proved than the obliteration by chronic inflammation. In order to endeavour to throw a little light on this yet obscure point, Dr. von Recklinghausen has sought for the determining causes of the formation of cysts in glands of the same nature as that which gives rise to ranula.

Practical experience corroborates the conclusions drawn from former researches. Gynæcologists are unanimous in admitting that the cysts of Bartholin's gland are in genetic relation with the inflammation with which this gland is frequently attacked. Perihepatitis of the upper surface of the liver is very frequent, especially in females; it is caused by the mechanical action of the border of the ribs, and occupies precisely the same position as the vibratile-celled cysts of the liver. As to the development of ranula, clinical observation has not given any posi-

tive results. It has been alleged that this tumour is especially noted amongst smokers; others have thought that it occurs especially in epileptics, in consequence of the bites which they give their tongue during the fits. Cooper asserts that singers are frequently attacked with ranula. These assertions have no foundation; all that can be said is, that the point of the tongue is sufficiently exposed to mechanical, thermic, and chemical irritations, for the inflammation to be produced from which Dr. von Recklinghausen traces the derivation of ranula.

Those who allow that all tumours have specific germs, might believe that Blandin and Nuhn's gland is capable of containing such a germ, and that the individual may at his birth have a predisposition to ranula. In fact, this tumour is sometimes congenital, and occupies a position in which embryonic aberrations are often observed. Moreover, the vibratile cells of the wall of the ranula seem to afford an argument in favour of this idea. In the normal condition, the excretory ducts of Blandin and Nuhn's gland have not really epithelium with vibratile cilia; they have only an ordinary cylinder epithelium. It may be answered to these objections that, in certain cases, variations in the epithelium have been observed; they are frequently discovered in ovarian cysts (Friedländer). In one of the cysts of Bartholin's gland, already described, still more remarkable new formations have been found: that is to say, granulation-tissue containing papillæ and gland-tubes.

It has besides been demonstrated that, in the animal kingdom, as in man, in certain physiological and pathological conditions, the form of the epithelial cells situated at a given point may vary considerably. Dr. von Recklinghausen quotes several examples of these transformations; and he concludes that the form of these cells, being variable, can only serve to recognise the progress of the phenomena of development.

As a practical result emanating from his researches, Professor von Recklinghausen recommends especially a thorough extirpation of the cyst at the point of the tongue. It is here that the source of the evil must be sought for, and not below, as has hitherto been done. Excision of the cyst, and extirpation or cauterisation of Blandin and Nuhn's gland, will prevent any recurrence.

EBERTH AND LETZERICH ON THE TYPHOID BACILLUS.

EBERTH (Virchow's *Archiv*, Band lxxxiii, p. 486) gives the results of the examination of seventeen cases of typhoid fever, with reference to the presence of bacilli. He compares these with eleven other cases of different infectious diseases, in which micrococci were found only exceptionally in the lymphatic glands, and no bacilli were present, and with thirteen cases of tuberculosis and phthisis, in which, in spite of the presence of extensive intestinal ulcers, no micro-organisms were found in the spleen or lymphatic glands. The ulceration of the intestine, here, as in typhoid fever, did not favour the entrance of micro-organisms. In six of the cases of typhoid, he found bacilli, generally in the glands, less often in the spleen; in eleven cases he found nothing. The average duration of the disease in the positive cases was rather longer than in previous observations. The number of bacilli was, on the whole, less; only in one early case (of fourteen days' duration) was it very large. The bacilli agreed in all respects with the earlier descriptions, but were not so abundant as in Klebs' cases. In addition, there were, besides the ordinary form, some long broad threads, perhaps only another phase of development.

Letzerich (*Arch. für Exp. Path.*, Band xiv, Heft 3), having observed that the hypostatic sputa of typhoid patients contained the typhoid bacillus in great quantity, cultivated it with care in isinglass jelly. He found that rabbits, infected with this material by hypodermic injection, sickened and died in about seven days. Dissection showed injection and swelling of the mucous membrane of the small intestine, and Peyer's patches; the spleen was enlarged. In another earlier series of experiments, in which [illegible] were washed micro-organisms from typhoid stools were employed, he found atrophy of the spleen. In those cases, he explains, by the longer duration of life of enlarged atrophy succeeding to the primary stage of enlargement; and he refers to the case of a rabbit placed by his children in the hutch he had used for these experiments, and which sickened and died in seven or eight weeks; on section, it showed atrophy of the spleen and numerous atrophic patches in the intestinal mucous membrane, with no Peyer's patches, but, in their place, thin transparent areas surrounded by a slightly thickened and pigmented edge. These experiments show that the typhoid poison may be introduced by other ways than the alimentary canal, and that the bacilli have the power of entering the blood-vessels and being transported with the blood-current. They leave the blood again, and pass into the tissues, either directly by diapedesis, or enter white corpuscles, which act as their carriers through the walls. Microscopical examination of the tissues of these animals showed the tissues, especially Peyer's patches, infiltrated with fungoid growth in [illegible] colour, probably derived from the colouring matter of the blood. Some cocci and bacilli, by endogenous division, which form network for the most part, but some become enlarged at each end, so as to assume a dumb-bell form. This infiltration leads to necrosis of the tissues. In the spleen, similar micrococci and bacilli, forming colonies, are found in the interstitial spaces, under the capsule, and between the elements of the organ. The small veins are often blocked by the growth, causing capillary hæmorrhages. In the lungs, there are inflammatory foci formed by the accumulation of lymphoid cells in the alveoli, between which are microcococci and spore-cells. The veins are often obstructed by fungoid growth.

In a postscript he adds that, after description of a fine thread-like form seeing Klebs' organism, he looked over his preparations carefully, and found it present in those follicles of the micro-process had not reached a high degree. These researches fully identify his earlier described 'micrococcus typhi abdominalis', with the 'bacillus typhosus' of Klebs.

ROBERT SAUNDBY, M.D.

RINDFLEISCH ON TUBERCULOSIS.

AFTER all that has been said and written on this subject, we seem little nearer unity than we were some years ago. Does the reason of this lie in the division of clinical medicine and pathology? The attempted dissociation of such a dissociation results of such a separate surgical subject of tumours, seen in the cog[illegible]

where clinical history is at least as important as ultimate histological structure. The pathology of tuberculosis must similarly consist, not merely in a histological examination of its ultimate products, but also in the careful tracing of its clinical history.

Tuberculosis, Professor Rindfleisch believes (Virchow's *Archiv*, 1881, Band lxxxv, pp. 71-83), is undoubtedly an 'infection-disease', but one for which mankind has, to a certain extent, established a tolerance, and which, therefore, appears in its original character only in the case of a person where this tolerance does not exist. Immunity from the outward manifestations of this latently universal disease depends, according to Professor Rindfleisch, on good food and a free blood-formation. These failing, tuberculosis becomes evident, and is then handed down by inheritance. The disease shows itself in a characteristic inflammatory process, under which Professor Rindfleisch reckons (1) disseminated miliary tuberculosis, the result of the tubercular poison alone, appearing in the form of miliary and submiliary nodules in most of the organs of the body; (2), the more localised miliary tuberculosis, where, in consequence of some local mechanical irritation, the disease appears only in a single organ (lung, brain, peritoneum); (3), localised miliary tuberculosis, where miliary tubercles are developed in the neighbourhood of an inflamed centre, ultimately finding their way into the inflamed tissue itself; and (4), inflammatory processes, especially ulcerations of chronic course, with little, or perhaps no, local formation of miliary tubercles, but very generally with tuberculosis of lymphatic glands. These inflammations, Professor Rindfleisch points out, occur from causes which, in ordinary circumstances, would scarcely produce a passing congestion. The inflammatory product consists, in the first place, in a slow growing deposition of white blood-cells in the connective tissue of the irritated parts. After a time, changes occur. 1. Part of the cells take an epithelioid character, and are termed tubercle-cells, being three to five times as large as white blood-cells. 2. Giant-cells are developed, which, however, are not to be regarded as characteristic of tubercle. 3. After the aggregations of epithelial cells have produced certain centres in the new growth, there appears a fine granular albuminous substance, either coagulated lymph, or developing zöoglœa masses, which, either separates, or involves in it the epithelial cells. 4. Lastly comes caseation of the inflammatory products owing to defective nutrition. These various peculiarities of the inflammation appear in the different forms of tuberculosis enumerated above. JAMES ANDERSON, M.D.

HUTCHINSON ON THE PRECANCEROUS STAGE OF CANCER, AND THE IMPORTANCE OF EARLY OPERATIONS.

IN a clinical lecture on this subject (*Brit. Med. Jour.*, January 7th), Mr. Jonathan Hutchinson observes: The patient who has just left the theatre is the subject of cancer of the tongue in an advanced stage. As I demonstrated to you, the lymphatic glands are already enlarged. It is hopeless to think of an operation, and there is nothing before him but death, preceded and produced by a few months of great and continuous suffering. His case, I am sorry to say, is but an example of what is very common. Not a month passes but a case of cancer of the tongue presents itself in this condition. The cases which come whilst the disease is still restricted to the tongue itself are comparatively few; nor does this remark apply only to the tongue. 'Too late! Too late!' is the sentence written but too legibly on three-fourths of the cases of external cancer concerning which the operating surgeon is consulted. It is a most lamentable pity that it should be so; and the bitterest reflection of all is, that usually a considerable part of the precious time which has been wasted has been passed under professional observation and illusory treatment. In the present instance, the poor fellow has been three months in a large hospital, and a month under private care. I feel free, gentlemen, to speak openly on this matter, because my conscience is clear that I have never failed when opportunity offered, both here and elsewhere, to enforce the doctrine of the local origin of most forms of external or surgical cancer, and the paramount importance of early operation. I have tried every form of phraseology that I could devise as likely to impress this lesson. Nearly twenty years ago, I spoke to your predecessors in this theatre concerning the 'successful cultivation of cancer'; telling them how, if they wished their patients to die miserably of this disease, they could easily bring it about. The suggestion was, that all suspicious sores should be considered to be syphilitic, and treated internally by iodide of potassium, and locally by caustics, until the diagnosis became clear. More recently, I have often explained and enforced the doctrine of a precancerous stage of cancer, in the hope that, by its aid, a better comprehension of the importance of adequate and early treatment might be obtained. According to this doctrine, in most cases of cancer of the penis, lip, tongue, skin, etc., there is a stage—often a long one—during which a condition of chronic inflammation only is present, and upon this the cancerous process becomes engrafted. I feel quite sure that the fact is so. Phimosis and the consequent balanitis lead to cancer of the penis; the soot-wart becomes cancer of the scrotum; the pipe-sore passes into cancer of the lip; and the syphilitic leucoma of the tongue, which has existed in a quiet state for years, at length, in more advanced life, takes on cancerous growth. The frequency with which old syphilitic sores becomes cancerous is very remarkable; on the tongue, in particular, cancer is almost always preceded by syphilis, and hence one of the commonest causes of error in diagnosis and procrastination in treatment. The surgeon diagnoses syphilis, the patient admits the charge, and iodide of potassium seems to do good; and thus months are allowed to slip by in a state of fools' paradise. The diagnosis, which was right at first, becomes in the end a fatal blunder, for the disease which was its subject has changed its nature. I repeat that it is not possible to exaggerate the clinical and social importance of this doctrine. A general acceptance of the belief that cancer usually has a precancerous stage, and that this stage is the one in which operations ought to be performed, would save hundreds of lives every year. It would lead to the excision of all portions of epithelial or epidermic structure which have passed into a suspicious condition. Instead of looking on whilst the fire smouldered, and waiting till it blazed up, we should stamp it out on the first suspicion. What is a man the worse if you have cut away a warty sore on his lip, and, when you come to put sections under the microscope, you find no nested

cells? If you have removed a painful hard-based ulcer of the tongue, and with it perhaps an eighth part of the organ; and, when all is done, and the sore healed, a zealous pathological friend demonstrates to you that the ulcer is not cancerous, need your conscience be troubled? You have operated in the precancerous stage, and you have probably effected a permanent cure of what would soon have become an incurable disease. I do not wish to offer any apology for carelessness, but I have not in this matter any fear of it.

MARCY ON THE DEVELOPMENT OF THE OSSEOUS CALLUS

IN FRACTURES OF THE BONES OF MAN AND ANIMALS.

FROM the study of fractures of bones in man and animals, and especially from a number of experiments made on rabbits, Dr. Marcy (*Ann. of Anat. and Surg.*, Feb. 1881) arrives at the conclusion that the doctrine of the formation of the callus, either as taught by Ollier, *i.e.*, as being derived from the osteogenetic layer of the periosteum, or by Billroth, *i.e.*, as being formed by the medulla of the Haversian canals of the extremities of the fractured bone, is untenable.

Professor Ercolani of Bologna had already maintained that neither the periosteum nor the extremities of the fractured bone are concerned in the formation of the osseous callus, but that, on the contrary, the periosteum becomes destroyed in the place where the callus is formed. Dr. Marcy finds, that the material forming the soft callus in the first days after a fracture is furnished from the blood of the lacerated vessels both of the connective and of other tissues injured, including those of the medulla and Haversian canals. That, however, the part the medulla takes in the formation of the callus is, in some cases, in the long bones, not indispensable, is proved by the fact that, in the bones of birds, which have no medulla, a well-formed callus may be met with. In man and animals, where the fragments of the broken bone are kept apart, the medulla takes no part in the formation of the osseous callus, this being entirely of external origin, and the surfaces of the separated fragments remain inert.

Dr. Marcy, having examined several specimens of healed fractures in animals, and also a large number in man, found definite evidence of atrophy of the extremities of the fractured bone. In fissures, or partial fractures in bones, especially of the cranial vault, there is no new formation taking place from the borders of the fracture, but distinct evidence of absorption and atrophy. These changes may be referred to the destruction of the periosteum at the place of injury.

From a series of carefully conducted experiments on rabbits, Dr. Marcy obtained specimens of fractures of the bones of the leg from the third to the twenty-fourth day. These were injected with blue gelatine solution from the aorta, and, after decalcification, sections were cut therefrom and examined with the microscope. The deductions made from this examination are these: the old periosteum at the point of injury becomes destroyed; the exudation from the parts surrounding the fracture is well developed as early as the sixth or eighth day, and covered with a new periosteum. In common with Ercolani, the author finds 'that the new periosteum impresses its osteogenetic action on the exuded cellular elements, and that it is by this that they are transformed into bone'.

[From the description of the appearances in the microscopical specimens as given in the paper, it appears, that the formation of the osseous callus takes place in essentially the same manner as that described by Billroth; that is to say, the new blood-vessels and the cells of the soft callus, as well as the new periosteum—or, rather, its osteogenetic layer, it seems, are derived from the medullary tissue of the Haversian canals at the extremities of the fractured bone.—*Rep.*] E. KLEIN, M.D.

LEVIS ON THE TREATMENT OF HYDROCELE AND SEROUS CYSTS IN GENERAL BY THE INJECTION OF CARBOLIC ACID.

DR. R. J. LEVIS, Surgeon to the Pennsylvania Hospital, and to the Jefferson College Hospital, Pennsylvania, in a paper reported from the *Transactions of the Medical Society of the State of Pennsylvania*, says: The objects of the operative procedures employed for the radical cure of hydrocele of the vaginal tunic of the testis is the obliteration of the serous sac, either by the process of suppuration, or the induction of plastic exudation through a lower grade of inflammation. There can be no question in the minds of practical surgeons as to the greater advantages of its accomplishment by the latter plan, and it is only necessary that it shall be rendered more controllable and more certain in its results to insure its exclusive adoption.

Since the method of cure by the suppurative process has been generally abandoned and condemned as too prolonged, painful, and dangerous, a variety of substances have been used for injection into the sac to produce the desired inflammation of its serous lining. It is the object to produce an inflammation which shall neither fall short of, nor exceed in its intensity, the plastic grade. The substances generally used for this purpose do not act with sufficient certainty in securing this result, and their action is painful and not sufficiently under control.

My experiments on the subject have been directed with the object of determining what substance can best secure the obliteration of the secreting surface and the adhesion of the walls of the cyst, with the most certainty and the greatest freedom from suffering and danger. With the impression that a degree of inflammation not transcending that of plastic exudation could be produced by carbolic acid, in November 1871, at the Pennsylvania Hospital, I injected for the first time one drachm of the deliquesced crystals into the sac of a large hydrocele. Having been previously accustomed to use for this purpose the tincture of iodine, and having witnessed the suffering which follows, I was at once surprised to find that the new procedure was entirely painless. The patient spoke only of a sense of numbness, and no inconvenience was felt until, on the succeeding day, the desired inflammatory condition became developed. Since that time I have always resorted to this material for the treatment of hydrocele in all my cases in the Pennsylvania Hospital, in the Jefferson College Hospital, and in private surgical practice, and now, after an experience of more than nine years, believe it to be the most satisfactory for the object.

For the purpose, crystallised carbolic acid is maintained in a liquefied state by a five or ten per cent. addition of either water or glycerine, the quantity of the diluent to be added varying with the quality of the article, and with the temperature of the apartment; but it is an object to reduce the crystals to a fluid state with no more dilution than may be necessary. Liquefaction could readily be effected by the application of a moderate amount of heat, but reduction of heat might produce solidification in the cannula.

After the usual tapping of the sac, I inject the liquefied crystals of carbolic acid with a syringe, having a nozzle sufficiently slender and long enough to reach entirely through the cannula. The illustration represents the syringe, reduced to one-half the proper size. The object of having this special form of instrument is to insure the placing of the injecting material entirely within the cavity of the cyst, without any reflow which would irritate the surface of the skin of the scrotum or of the fingers of the operator, and without the possibility of injecting it into the connective tissue between the skin and the tunica vaginalis. This form of syringe is supplied by the leading surgical instrument-makers.

The quantity injected varies in accordance with the size of the tumour, from thirty to sixty grains. Thirty grains of undiluted carbolic acid is the smallest amount that I have used, and the largest quantity a drachm and a half.

As soon as the carbolic acid is lodged within the sac, the scrotum is freely manipulated by the fingers of the operator, so as to diffuse it over the lining walls of the hydrocele. A sense of warmth is produced, which is quickly followed by a decided numbness, and the patient is at once able to walk about and to attend to his ordinary duties without inconvenience. I have not been in the habit of enforcing rest on the patient until after the lapse of twenty-four hours or a longer time, when intrascrotal inflammation renders quietude agreeable or imperative.

I have never, after this procedure, been able to detect any general toxic effects from the absorption of carbolic acid. Such systemic manifestations as general depression, and the characteristic evidence of the brown discoloration of the urine, I have looked for with negative results. I believe that the action of strong carbolic acid on surfaces secreting albuminous fluids is to seal them, and, as it were, to so shut them off from the system, that absorption cannot readily take place. This sealing of an absorbing surface involves a surgical principle in antiseptic treatment which is applicable in very many instances in which denuded or ulcerating surfaces are exposed to septic infection. I state it as an important surgical resource that, in certain compound fractures and destructively lacerated wounds, where septic exposure is inevitable, the danger from absorption may be averted by producing the occluding influence of strong carbolic acid.

Within my own experience, no failure to radically cure hydrocele in the manner I present has, to my knowledge, occurred. I have never failed to produce with carbolic acid the proper amount of inflammation within the walls of the sac, but have been informed that such failures have occurred in other hands, yet do not know the particulars of the treatment and results in those cases. In no case of hydrocele or other simple serous cyst have I seen inordinate inflammation or suppuration follow injection. In a case of cyst within a disorganised testicle, which was probably sarcomatous, treated with the injection of carbolic acid, high inflammation and suppuration occurred. In three instances of hydrocele of the tunica vaginalis testis, in which the previous injection of the tincture of iodine had failed, carbolic acid made a permanent cure.

I do not propose to determine, in the entire range of cases of serous, synovial, and mucous cysts, those to which this treatment is applicable. All forms of cysts which are usually subjected to any form of operative treatment on the principle of producing plastic adhesion of their walls, such as intrascrotal cysts and those of the anterior region of the neck, may be deemed amenable to the treatment here indicated. A large class of synovial bursæ, whether they be enlargements of the normal bursal sacs of the body, or adventitious formations developed by friction or pressure, are proper cases for this treatment. The bursal developments which occur on salient points of the limbs, as those over the patella and on the olecranon process, called respectively housemaid's knee and miner's elbow, can be safely and effectively treated by very free incision, emptying the contents, and then mopping the cyst-walls thoroughly with undiluted carbolic acid, deliquesced simply by heat. A dressing of carbolised oil or ointment is then continued until cicatrisation is completed.

I believe that in carbolic acid we have a means, if properly used, of producing almost uniformly the proper plastic inflammation necessary for the radical cure of hydrocele and other serous cysts, which are usually deemed amenable to treatment on such principle, and I recommend its use to the profession.

HAYES ON TRIPIER'S AMPUTATION OF THE FOOT.

Chopart's method of disarticulation through the median tarsal joint, performed for the first time ninety years ago, though received at first with approval with most surgeons, is now seldom performed in this country, and, since 1860, has ceased to be favoured in France. It was soon found that many healed stumps are apt to assume most unsatisfactory conditions. The heel is liable to become upwards and backwards, and the cicatricial tissue on the anterior and depressed portion of the stump to undergo ulceration or to become very tender. Besides this so-called equinisation, and the consequent mischief affecting the soft parts, disease may attack the os calcis, and necessitate a secondary amputation. Within the past two years, Professor Tripier of Lyons has proposed an operation calculated to overcome all the defects associated with Chopart's method. Mr. Hayes of Dublin has tested this new operation upon two occasions, and, in a recently published reprint of an article in the *Dublin Journal of Medical Science* for December last, expresses his full belief that this method deserves to occupy a high position amongst the many valuable achievements of the French school of surgery.

The following description is given of Tripier's amputation. 'The surgeon's knife is made to take the following course. Commencing at the outer edge of

the tendo Achillis, on a level with the external malleolus, a skin-wound is to be made in a direction at first downwards and forwards, and afterwards forwards, so as to pass two finger-breadths below the malleolus, and then to approach by a finger's-breadth the upper part of the base of the fifth metatarsal bone. From this point the incision is to be carried upwards, forwards, and inwards, so as to reach the inner margin of the tendon of the extensor proprius pollicis, just behind the first tarso-metatarsal articulation. The knife should now be made to cut downwards and forwards, so as to enter the sole of the foot a finger's-breadth in front of the dorsal wound. The incision is then to be carried, with a gentle forward curve, outwards and backwards, until it can be made continuous with the first portion of the wound below the outer malleolus. The divided integument having undergone some degree of retraction, the dorsal and plantar structures are to be divided half an inch behind the superficial wound; the soft parts are then to be separated from the bones, extreme care being taken to preserve uninjured the vessels contained in the inner part of the plantar flap. The surgeon will find it convenient at this stage to disarticulate the cuboid and scaphoid from the os calcis and astragalus, just as in Chopart's amputation. Having done so, he will proceed to divide and separate the periosteum from the under surface and posterior extremity of the os calcis up to the level of the sustentaculum tali, where the bone is to be sawn through in a direction from behind and within, forwards and outwards, so to leave a surface, which will be at right angles with the axis of the tibia, when the limb is caused to assume the ordinary position for walking or standing. All sharp edges and angles of bone should now be rounded off. The posterior tibial nerve should be exposed in the plantar flap, and divided as high as possible, with a view to prevent risk of neuroma. The vessels having been secured, the flaps are to be brought together, and the limb so dressed as to secure moderate flexure of the ankle-joint during the period of repair.'

The chief advantages belonging to this operation of Professor Tripier, are stated to be these. 1. Comparatively short flaps will be found quite sufficient to afford complete covering for the surfaces of bone. 2. Tendons will have been divided well in front of their sheath-connections with the astragalus and os calcis, so that, when they form new attachments, the muscles which act upon them will be capable of regulating flexion and extension of the ankle-joint. 3. Section of the os calcis will at once prove whether the bone is healthy throughout, and, in the event of there being any evidence of central disease, the operation can readily be converted into one of disarticulation at the ankle. 4. Removal of the lower part of the os calcis, in the manner described, leaves an extremely broad even surface, which at once secures the patient against risk of subsequent distortion, and causes pressure to be diffused over such a considerable extent of soft tissue as to render the chance of ulceration well-nigh impossible. Besides other advantages attendant on this operation, the wound heals rapidly, and, within a very short space of time, the limb becomes capable of sustaining the whole weight of the body.

W. Johnson Smith.

MOORE AND BIRDWOOD ON THE OPIUM QUESTION.

Deputy Surgeon-General W. J. Moore, Bombay Army, writes that there is evidence that the Chinese were formerly a very drunken nation. Opium smoking has succeeded the tendency to spirit drinking, principally from the cheapness of opium as compared with spirits. If it were possible to prohibit opium altogether to the Chinese, alcohol, or some other stimulant, would take its place, or there would be a new departure in the history of nations. Thirst for stimulants has existed in all countries. When we have removed our own beam by performing the impossible feats of stopping all distilleries, pulling down all gin-shops, banishing all distillers, retail vendors, importers and exporters of alcohol, then it will be time to talk of 'the iniquity of the opium traffic, and of the moral obliquity of those concerned'. It must be admitted by the unprejudiced that the effects of opium are at least not worse than the injuries produced by alcohol.

Sir George Birdwood, formerly Professor of Materia Medica in the Medical College, Bombay, holds (*Times*, Jan. 20th and 31st, 1882) that opium-smoking is absolutely harmless. He does not place it in the same category with even tobacco-smoking, for tobacco-smoking, if carried to excess, may be injurious, particularly to young people. He considers that it is as harmless as smoking willow-bark, or inhaling the smoke of a peat fire, or the vapour of boiling water. The freedom of opium-smokers from bronchial and thoracic diseases is deserving of consideration. The Chinese converts to Christianity suffer greatly from consumption. The missionaries will not allow them to smoke; and, as they also forbid their marrying while young, they fall into those depraved habits of which consumption is the inexorable witness and scourge. When spitting of blood comes on, the opium-pipe is its sole alleviation. None of the active principles of opium are volatile. No effect is produced by opium-smoking beyond that pleasant and peaceful warmth throughout the body which comes of sitting over a peat fire on a chilly day, or inhaling the fragrant vapour from a bowl of whisky toddy as the boiling water is stirred into it. The alleged special aphrodisiac properties of opium should be entirely discredited. The general debauched habits of the lower outcast populations of the cities of China are responsible for their cachectic appearance, and not the accidental circumstance that some of them indulge in opium-smoking.

[Reference can also be made to the following writings on the subject. Stamford Raffles, *Java*, vol. i, pp. 111-12; Tod, *Rajasthan*, vol. i, 553; John Malcolm, *Memoir on Central India*, pp. 45, 76, 359; James Burnes, *Narrative of a Visit to the Court of Scinde, and a Sketch of the History of Cutch*, p. 230; John Crawfurd, *Dictionary of the Malay Archipelago;* W. C. B. Eatwell, *Selections from the Records of the Bengal Government on the System of Cultivating the Poppy, and of Preparing Opium in the Benares Opium Agency* (republished, *Pharmaceutical Journal*, 1851-2); Elijah Impey, *Report on the Cultivation, Preparation, and Adulteration of Malwa Opium*, Bombay, 1848; Tylor, *Anthropology*, p. 268; Benjamin Brodie, *Psychological Enquiries*, p. 248; Medhurst, *China;* Marsden, *Sumatra*, p. 278; O Shaughnessy, *Bengal Dispensatory*, p. 180; George Birdwood, *Vegetable Products of Western India;* Sirr, *China and the Chinese;* Long, *The Chinese as they are;* R. H. Cobbold, *Pictures of the Chinese;* Doolittle

Social Life of the Chinese; Osgood, *New York Medical Record*, 1878; Ayres, *Medical Times and Gazette*, 1878; Gardner, *Parliamentary Blue Book*, 1881; Chetun Shah, *Indian Medical Gazette*, March 1881; Minturn, *From New York to Delhi.—Rep.*]

William Murrell, M.D.

STILLMAN ON AN AID TO THE MECHANICAL TREATMENT OF WEAK ANKLES AND INVERTED FEET.

Dr. Charles F. Stillman of New York writes thus in the *New York Med. Record.* If we examine the ligamentous structure of the ankle-joint, we observe that externally the ligaments are placed so as to allow more mobility than internally—nature evidently relying upon the inherent contractile power of the peronei muscles to hold the foot at its natural angles with the leg, and to perform all necessary eversion. The weakness or insufficiency of these muscles is of itself a sufficient cause of the deformity we are considering, even though the supports of the joint be otherwise normal; but these may also be unduly relaxed. A tendency to turn the ankle under, to have it give way externally, to point the toes inward and downward, and an habitual stumbling, shuffling gait, are the main symptoms displayed.

The instruments which could hitherto be procured for the purpose of supporting the limb while the muscle is improving afforded support, but allowed only a vertical motion in the ankle-joint. This feature was shared by all, and is incorrect, since the normal degree of lateral movement should be permitted.

Dr. Stillman disapproves of Sayre's and Barwell's methods, and says:

Another form of apparatus used for producing eversion is Professor F. H. Hamilton's. It is not practicable except on level surfaces, but is very effective, and produces a true eversion.

Sayre's rotating screw is open to the objection that it allows no lateral movement at the ankle, and, therefore, while effective as a rotator, is useless in producing eversion; and, in Dr. N. M. Shaefer's and others, the fault is the same.

Dr. Gregory Doyle (*Trans. of the Amer. Med. Assoc. for* 1880-81) has recently devised an apparatus which is an arrangement for pulling the outside of the foot upward at various angles with the leg, by means of a spiral spring, and does not admit of a true local everson.

I have devised an apparatus for the cure of this condition which is effective, because it is physiological, and it exhibits several principles distinct from any heretofore introduced to the profession.

1. It consists merely of a steel strip worn outside the leg only, so that there is nothing on the inside to interfere with the child's walking, and is extremely light and comfortable. 2. It can be worn with any shoe, and is detachable at pleasure. 3. It is attached to the bottom of a shoe by a pivot in the centre of motion of the foot, thus allowing lateral motion in the ankle, a feature not possessed by any other form of apparatus. 4. The joint at the ankle is placed at the back of the heel, thus affording increased leverage for the action of the elastic cords and preventing the foot from going 'over the centre' when the cords are in action. 5. The traction produced by the elastic cords corresponds to the lines of direction of the force exerted by the peronei muscles.

There are two essentials to the complete and perfect action of this brace: first, the pivot should be located at or near the centre of motion of the foot; and second, if an everting cord be used, the girth about the leg should be prevented from rotating.

The centre of motion (Fig. 1) is the point where two bisecting lines meet when drawn through the foot while rotated at different angles; and, when a person stands erect, a line drawn vertically through the hip-joint should pass at or near this point; and

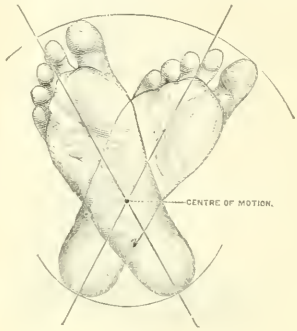

Fig. 1.

this is the proper position in which to place an attachment between a brace and shoe, instead of against the heel, as in all other forms of apparatus.

Fig. 2 exhibits the pivotal attachment of the brace to the shoe when the everting cord is not attached; and Fig. 3 shows the change produced by the action of the everting cord when attached.

Fig. 2.

Fig. 3.

The brace is simple, unique, and efficient in all cases of weak ankles and inverted feet. In weak ankles alone, without inversion, an elastic strap passing from the foot to the brace, as in Fig. 4, is to be employed.

Fig. 4.

Fig. 5.

If inversion alone be present, the elastic cord is adjusted, as shown in Fig. 6 after the fixation of the

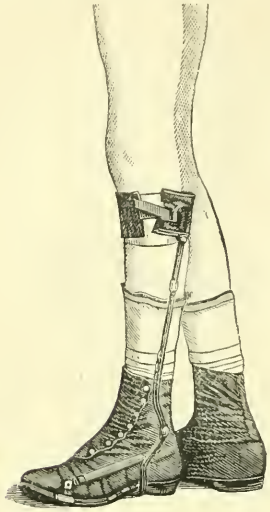

Fig. 6.

girth. If both conditions be present, both cords must be employed, as in Fig. 5.

E. NOBLE SMITH.

THERAPEUTICS AND PHARMACOLOGY.

RECENT PAPERS.

1. BUZZARD. — Arsenic in Spasmodic Torticollis. (*Brit. Med. Jour.*, Dec. 1881.)

2. FAGGE.—Salicylates in Acute Rheumatism. (*Lancet*, Dec. 1881, p. 1030.)

3. STRANGE.—Salicylic Acid as a Specific in Acute Rheumatism. (*Brit. Med. Jour.*, Dec. 1881, p. 1012.)

4. CLAY.—Chian Turpentine in Cancer. (*Lancet*, Dec. 1881, p. 1033.)

5. NEALE.—Suggestions for treating Hydrophobia. (*Lancet*, Dec. 1881. p. 1070.)

6. SPARWAY.—Asclepias as a Diuretic. (*Brit. Med. Jour.*, Dec. 1881, p. 978.)

7. MILLICAN.—Ergotine used locally in Erysipelas. (*Brit. Med. Jour.*, Dec. 1881, p. 935.)

8. WOLFLER.—The Use of Iodoform in Affections of the Mouth. (*Centralbl. fur Chir.*, No. 48, 1881.)

9. SCHÆFFER.—The Action of Mydriatics. (*Archiv für Ophthal.*, vol. x; and *Gaz. Hebd. de Méd.*, Jan. 13, 1882.)

10. LUTON.—The Treatment of Alcoholism. (*Gaz. Hebd. de Med.*, Jan. 30, 1882).

11. BOECHAT.—Treatment of Goître by Iodoform. (*Correspond. fur Schweizer Aerzte*, No. 1, 1882.)

12. GUILLEMIN.—Inhalation of Medicated Vapours in Diseases of the Respiratory Organs. (*Arch. Med. Belges*, July 1881.)

13. ANTHONI. — New Formula for Balsamic Pills. (*Thérap. Contemp.*, June 1, 1881.)

14. STREITZ. — The Hypodermic Administration of Mercurials in Syphilis. (*Arch. Med. Belges*, July 1881; and *New York Med. Record.*)

15. MARTINEAU.—Subcutaneous Injection of Ammoniated Mercurial Peptone in Syphilis. (*Revue de Méd. et de Chir. Prat.*, Dec. 1881.)

16. GRESLON.—The Treatment of Sciatica by Hypodermic Injection of Nitrate of Silver. (*La France Méd.*, Sept. 26, 1881.)

17. SALOMON. — Therapeutic Uses of Yerba Santa. (*New Orleans Med. and Surg. Jour.*, Nov. 1881.)

18. MALHERBE.—Tartar Emetic in Chorea. (*Jour. de Méd. de l'Ouest.*)

19. TAURET — Solutions of Caffeine for Hypodermic Injection. (*Gaz. Hebdom. de Méd.*, Jan. 6)

20. VIGIER.—Solution of Alkeloids in Oil or Glycerine. (*Gaz. Hebd. de Med.*, Jan. 6, 1881.)

21. STITES.—Ergot in Lead-Palsy. (*Therap. Gaz.*: and *Philad. Med. and Surg. Rep.*, Nov. 19, 1881.)

22. Ergotine in Pharyngitis. (*La Revue Mens. de Laryngol.*)

23. RIOPEL.—Collodion in Rheumatism. (*Med. and Surg. Reporter*, Oct. 8.)

24. PORTER. — Eruption from Oil of Tanxy. (*New England Med. Jour.*, Oct. 15.)

25. LEWIN and ROSENTHAL.—The Form taken by Chrysarobin in External and Internal Use. (Virchow's *Archiv.* Band lxxxv.)

26. RIBBERT.—The Effect of Tannic Acid in Albuminuria. (*Centralbl. für die Med. Wiss.*, No. 3, 1882.)

27. GUTMANN.—The Action and Uses of Aspidospermin. (*Archiv für Exper. Pathol. und Pharm.*, Heft vi.)

28. STADELMANN. — The Action of Toluylenidamin. (*Archiv für Exper. Pathol. und Pharm.*, Heft v.)

29. DONATH.—The Physiological Effects and Chemical Reactions of Chinotine. (*Berichte der Deutsch. Chem. Gesells.*, No. 14, 1881.)

30. GNAUCK.—The Action of Hyoscine. (*Centralbl. fur die Med. Wiss.*, No. 45, 1881.)

31. BEETZ. — Iodoform Insufflations in Laryngeal Phthisis. (*Berl. Klin. Woch.*, No. 2, 1882.)

1. *Buzzard on Arsenic in Spasmodic Torticollis.* —In the *Brit. Med. Jour.*, Dec. 1881, p. 937, Dr. Buzzard reports a case of this disease, cured by the use of liquor arsenicalis in five-minim doses, thrice a day. Dr. Buzzard remarks that the pathology of such cases is still obscure. They often resist long and varied treatment. When recovery takes place, it is always in young women. In one case that had been under Dr. Buzzard's care, firm pressure in the left ovarian region controlled, for a time, the spasm.

2. *Fagge on the Use of Salicylates in Acute Rheumatism.*—Dr. C. Hilton Fagge has contributed one to a long series of valuable papers in recent numbers of the *Lancet* (Dec. 1881, pp. 1030), confirming the great powers, said to be possessed by salicin, salicylic acid, and salicylate of soda, in the treatment of acute and chronic forms of rheumatism. Sufficient distinction is scarcely made between the various drugs, most writers classing them under the heading, Salicylic Acid and its Compounds.

3. *Strange on Salicylic Acid as a Specific in Acute Rheumatism.*—Dr. W. Strange, among many other contributors to the *Brit. Med. Jour.*, Dec. 1881, p. 1012, bears testimony to the specific action of salicin and its congeners in the treatment of acute rheumatism.

4. *Clay on Chian Turpentine in Cancer.* — Mr. John Clay, in the *Lancet*, Dec. 1881, p. 1033, reiterates all his previous assertions regarding the value of Chian turpentine in cases of cancer. (*Vide* LONDON MEDICAL RECORD, 1880, pp. 142, 316, 446). As in cases of vaginal cancer, vinegar injections and insufflations of powders, composed of charcoal, sulphate of copper, and tannin, were combined with the

use of the turpentine, any good resulting could not be claimed entirely by this latter drug. In the *Brit. Med. Jour.*, Dec. 1881, p. 1037, a case at Brighton is stated to have improved while taking the turpentine.

5. *Neale on Suggestions for Treating Hydrophobia.*—In the *Lancet*, Dec. 1881, p. 1070, Dr. Richard Neale suggests, after careful study of the numerous cases of hydrophobia that of late years have been recorded in the medical journals, the following plan of treatment, as one likely to yield the best results: 1. The Turkish bath, from which more benefit has been hitherto derived than from any other mode of treatment; 2. Jaborandi or pilocarpin, in order to eliminate as much of the poison from the salivary glands as possible; 3. Filling the air with antiseptic vapours, such as iodine, eucalyptus oil, or thymol, in order to destroy, if possible, any germs circulating in the body generally; 4. Relieving the spasms of the throat by small hypodermic injections of morphia over the sensory portions of the superior laryngeal nerve, as done by Rossbach previously to operations about the larynx; 5. Securing a sufficient supply of water to the system, in order to wash out the waste products of the body, either by enema, or by instilling water into the peritoneal cavity by the aid of Southey's tubes; 6. Keeping the patient actively employed, both in mind and body; 7. The judicious use of curara, a drug that has often proved very valuable in relieving many of the most urgent symptoms, but one better omitted, if possible. In the first edition of the *Medical Digest*, twenty-nine remedies were noticed as recommended, more or less highly, in the treatment of hydrophobia. During the last few years, sixteen additional specifics (?) have been placed on record.

6. *Spurway on Asclepias as a Diuretic.* — Mr. Chas. Spurway, in the *Brit. Med. Jour.*, Dec. 1881, p. 978, speaks highly of the diuretic powers of the asclepias syriaca, or common milk-weed, of America. Mr. Spurway employed the remedy, after failure with all other known diuretics, in a case of cardiac dropsy. While recognising the important part played by tapping and milk-diet, which were employed in this case, Mr. Spurway is so convinced of the efficacy of the drug, that he hastens to bring it before the profession.

7. *Millican on Ergotine used Locally in Erysipelas.*—Mr. K. W. Millican, in the *Brit. Med. Jour.*, Dec. 1881, p. 935, states that a solution of ergotine (1 in 50) is a most valuable application in facial erysipelas, and begs that a trial may be made by others, and its effects reported. R. Neale, M.D.

8. *Wölfler on the Use of Iodoform in Affections of the Mouth.*—Dr. Anton Wölfler of Vienna has been led by experience of the favourable course of open and deep wounds, when dressed with iodoform, to try the value of this agent when applied to similar open surfaces situated just within the natural orifices of the body—regions to which it is difficult to apply dressings under antiseptic conditions. In the *Centralb. fur Chir.*, No. 48, 1881, this surgeon gives the general results of the use of iodoform dressings, in eighteen cases of removal of more or less of the tongue for carcinoma, by Professor Billroth, during a period of six months. In several of these cases, much of the floor of the mouth was removed, together with the corresponding submaxillary gland and affected lymphatic gland; and in some it was found necessary to perform partial resection of the lower jaw. In all the cases, according to Professor Billroth's usual practice, the lingual artery was tied at the beginning of the operation, and occasionally both lingual and facial arteries had to be previously secured. All the patients recovered, and, Dr. Wölfler states, without any decided elevation of temperature, and without the occurrence of any of the serious traumatic complications and local reactions which occur frequently after operations on the tongue. In each case, the raw surface in the mouth was dressed by a long and narrow strip of gauze that had been prepared with resin, in alcoholic solution and glycerine, and dusted over, whilst still moist, with finely powdered iodoform. The strip of gauze was allowed to remain in contact with the wound for about a week. The small quantity of iodoform contained in the strip of prepared gauze is sufficient to maintain the wound completely and permanently aseptic; and it is to the action of this dressing that the excellent results in the above-mentioned cases of lingual carcinoma are, Dr. Wölfler holds, to be regarded as directly due. If the results of these cases be compared with those previously observed after extirpation of the tongue, one must arrive at the firm conviction, according to Dr. Wölfler, that for wounds in the mouth we have, in iodoform, a convenient and very reliable antiseptic dressing. W. Johnson Smith.

9. *Schæffer on the Action of Mydriatics.* — The comparative effect of duboisine and homatropine on the eye have been investigated by Schæffer (*Archiv fur Ophthal.*, vol. x, p. 196; *Gaz. Hebd. de Méd.*, Jan. 13, 1882, p. 28). In man, the effect on the pupil of atropine locally applied was to cause mydriasis in fourteen or fifteen minutes, persisting to the fourth day. Duboisine produced dilatation in six or eight minutes, lasting about four days. Homatropine induced dilatation in nine minutes, but it lasted only three hours. As regards accommodation, this was influenced more rapidly (in ten minutes) with duboisine than with atropine (twenty-three minutes). The maximum of intensity was reached in an hour and a half after dilatation by duboisine, and in the same time with homatropine. It disappeared, however, more quickly with homatropine than with the other two alkaloids. Therapeutically, where a temporary effect only is required, homatropine may prove more serviceable than atropine or duboisine.

10. *Luton on the Treatment of Alcoholism.*—M. Luton (*Gaz. Hebd.*, Jan. 13, 1882, p. 30, from a separate memoir) proposes to treat acute alcoholism by strychnia. In delirium tremens, he would employ hypodermically doses of one-twelfth of a grain two or three times a day. When given by the mouth, he does not hesitate to recommend nearly half a grain (30 milligrammes) of strychnia to be taken daily.

Thomas Stevenson, M.D.

11. *Boéchat on the Treatment of Goître by Iodoform.*—M. Boéchat has used iodoform in the treatment of goître as follows (*Corresp. für Schweizer Ærzte*, No. 1, 1882). 1. For external application, the writer used a glycerole of iodoform, which he covered with a layer of collodion. The results were negative in long-standing cystic or parenchymatous goîtres; on the contrary, in fresh goîtres of a soft consistence, the tumour diminished more rapidly than with iodine or iodide of potassium, but the odour was a serious drawback. 2. For internal use, M. Boéchat prescribed iodoform in pills of 1 centigramme each, giving not more than ten daily. This treatment was only used in the case of two patients having long standing goîtres. 3. M. Boéchat submitted three cases to interstitial injections; the first patient, who had had a goître since his childhood, was subjected for a fortnight to the injection of the

half of a Pravaz's syringe of saturated solution of iodoform in ether. This application was suspended in consequence of a very intense inflammatory reaction, but the goitre had diminished very notably. In the second case, two injections were sufficient to induce improvement in the old standing goitre; in the third case of goitre, suppuration came on without other improvement. Finally, M. Boéchat is of opinion that this is an useful method which it would be well to make known generally.

12. *Guillemin on Inhalation of Medicated Vapours in Diseases of the Respiratory Organs.*—After a careful and minute study of this important therapeutic question, the author thus summarises his impressions (*Archives Méd. Belges*, No. 1, July 1881). 1. The affections of the mucous membrane of the respiratory passages may in certain cases be advantageously treated by inhalations of medicated vapours. 2. In the first stage of acute inflammation of this mucous membrane, pain, cough, and painful sensations, which are the consequence of irritation and dryness, are rapidly calmed by inhalations of warm, moist, and aromatic vapours. 3. The calming action is still more decided if to the liquid, which serves for inhalation, there be added a small quantity of certain volatile calmative substances such as ether, distilled cherry-laurel water, or conium. 4. Frequently renewed inhalations of essence of turpentine, when they are administered at the commencement of the first period of inflammation, may arrest its progress. 5. The vapour of iodine exercises an irritant action on the mucous membrane of the air-passages. It induces efforts of coughing, and augments the secretion of the mucus of the air-passages. This irritating action may be utilised: (*a*). To diminish the swelling of the mucous membrane by causing the inflammation to pass from the first to the second stage; this indication is present especially in cases where the inflammation occupies the small bronchi; the swelling of the mucous membrane is sufficient to give rise to fear of respiratory insufficiency; (*b*) To diminish the viscosity of the products of morbid secretion by their admixture with the mucus, of which the vapours increase the formation; (*c*). To induce efforts to cough, and to disembarrass the air-passages from the products which are there accumulated. 6. It is not only by its irritating properties that the vapour of iodine modifies the mucous membrane of the air-passages. Iodine, in reality, possesses the property of stopping purulent secretion, and, on the other hand, it arrests and prevents putrescence. Thus, when the mucous membrane of the air-passages yields a purulent secretion, resulting either from an acute inflammation in the third stage, or from a chronic inflammation, the inhalations of iodine will determine by degrees the quantity of pus, and finish in certain cases by entirely changing the nature of the secretion, which becomes completely mucous. 7. Although the essence of turpentine, in the fluid condition, is a sufficiently powerful irritant for the tissues with which it is placed in contact, inhalation of this essence is easily supported by the mucous membrane of the air-passages. It only brings on very moderate irritation, and very rarely provokes fits of coughing. 8. When the mucous membrane is affected, and yields a product of secretion, these vapours have the effect of diminishing the quantity and augmenting the consistence of this. 9. If the product of secretion be purulent, the inhalation of essence of turpentine, continued during a sufficiently long time, progressively diminishing the quantity of pus, may, in certain cases, completely stop the secretion. The inhalations are indicated in all affections of the larynx, of the trachea, and of the bronchi, when accompanied by a very copious muco-purulent secretion without viscosities. On the other hand, the use of them must be avoided whenever expectoration is difficult, in consequence of the too great viscosity of the products of secretion. 10. In cases when these products are at the same time very copious and very viscous, it is possible, by alternate inhalations of vapours of iodine and vapours of turpentine, to rapidly diminish the quantity of secretion without increasing its viscosity. The inhalation of iodine should always be used in the first instance. 11. Inhalation of essence of turpentine is indicated in hæmoptysis, and is very successful in cases of hæmoptysis of average intensity.

13. *Anthoni's New Formula for Balsamic Pills.*—Dr. Anthoni, in the *Thérapeutique Contemporaire*, June 1, 1881, p. 343, gives the following prescription for balsamic pills: Extract of cinchona calisaya, 30 grammes; extract of conium, 1 gramme; balsamic tincture, 50 drops; marshmallow powder, q.s. Spread the extracts on a marble slab, add 10 drops of balsamic tincture, and mix with a knife or spatula; add again 10 drops of tincture, mix, and add 10 drops more, and go on in the same way until the 50 drops are incorporated. Spread the paste on the slab and let it dry for two hours, then add the necessary quantity of marshmallow powder, and form a mass which can be divided into 100 pills; silver these pills, or, still better, cover them with a layer of sugar. These balsamic pills are useful in simple phthisis, phthisis which is neither compound nor complicated. In simple phthisis, Dr. Anthoni has definitively given up the use of arsenical compounds, of cod-liver oil, quinine wine, antiscorbutic syrup, creasote, petroleum, sulphur, and all those drugs which only irritate the mucous membrane of the stomach, and disturb the digestive functions. He only gives these balsamic pills twice daily, one at breakfast and one at supper. These pills and a suitable manner of life are sufficient for the treatment of this form of phthisis. In compound or complicated forms of phthisis, he gives at the same time with these pills the medicines indicated, by the complicating affections, unless there be some gastric disorders to be overcome; in that case, he dispenses with their use until the digestive functions are restored to their normal condition.

14. *Streitz on the Hypodermic Administration of Mercurials in Syphilis.*—Guided by the counsels of Lewin in Berlin, Pick in Prague, and Sigmund in Vienna, Dr. Streitz has conducted a long series of experiments on the subcutaneous use of mercurials in syphilis, at the military hospitals in Brussels. The results of his studies are published in *Les Archives Méd. Belges*, July 1881; and *New York Med. Rec.* The most simple mercurial solution for hypodermic use was suggested by Lewin of Berlin. It is the following: R. Hydrarg. bichloridi, 40 ctgr. (6 gr.); sodii chloridi, 5 grm. (75 gr.); aquæ destillatæ, 40 grm. (3 x.); morph. hydrochloratis, 20 ctgr. (3 gr.) Calomel is not adapted to hypodermic use. The cyanide of mercury may be employed in doses of from 1 to 5 milligrammes. The albuminate and the peptonate of mercury, originally prepared by Bamberger of Vienna, are the safest solutions of all, never producing abscesses or other lesions. The peptonate of mercury is prepared by the following process: (1) 1 grm. (15 gr.) is dissolved in 50 c.c. of distilled water and filtered; (2) 1 grm. (15

gr.) of sublimate is dissolved in 20 grm. (ʒ 5) of water, and the solution mixed; a precipitate is formed, which is redissolved in 15 grm. (ʒ 3¾) of a 20 per cent. solution of chloride of sodium. The solution now measures 85 c.c. Enough distilled water is added to make 100 c.c. The solution is allowed to stand one or two days, and is then filtered. Each gramme of the solution contains 1 ctgr. of the peptonate. Iodo-peptone is a preparation suggested by Pick of Prague, in which the iodide of potassium replaces the chloride of sodium in Bamberger's solution, above referred to. The combined effect of the iodide and the mercurial are obtained from this preparation, which has given great satisfaction. Dr. Streitz divided his observations into different groups, with a view to ascertaining certain facts. 1. The patients of the first group had reached different stages of syphilis. The object was, in this instance, to discover the solutions possessing the greatest number of advantages, and the places best adapted to injections, and the proper dosage. The solutions selected were those given above. Since they cause the least pain, one-half or two-thirds of a Pravaz's syringeful should be injected into the deep cellular tissue. 2. The second group includes only patients treated at the beginning of the disease, after the chancre had disappeared. In all these patients the cutaneous symptoms were observed, but were not well marked. The eruptions were discrete, being in some places hard to detect, and rapidly disappeared. 3. In the third group, treatment was not instituted until after the appearance of the eruption. The symptoms disappeared quite as promptly as, and even more rapidly than, when other methods of mercurial treatment were employed. Six months after the injections were given, only one case among all those treated had experienced a relapse, which showed itself as a papular syphilide, although, as a rule, only 15 or 20 centigrammes of the sublimates had been given, divided among thirty or forty injections. The advantages of this method of treatment, as stated by the author, are: the precision in the dosage, the harmlessness of the injections and the integrity of the digestive organs which they insure; no deception can be practised; mercurial stomatitis is avoided; no abscesses need result; the cure is rapid. The author further says that secondary symptoms, in patients who had not been treated until the development of the symptoms, disappeared much more rapidly than when treated by other methods; the average period of duration for the papular syphilides was two weeks. Although injections given early—so soon as chancre was certainly diagnosticated—did not prevent secondary symptoms, the latter were but slightly marked. The injections were particularly efficacious in subduing glandular enlargements at all stages of the disease.

15. *Martineau on Subcutaneous Injections of Ammoniated Mercurial Peptone in Syphilis.*—Subcutaneous injections of mercury in syphilis, after having been somewhat neglected, have been lately studied by M. Martineau, who has employed them extensively in his practice at the Lourcine Hospital (*Revue de Méd. et de Chir. Pratiques*, Dec. 1881). Injections offer certain advantages which give them great practical value. They never induce salivation, nor bring on any disturbance of the digestive functions, so that they can be administered to patients to whom, on account of their general condition, it would be impossible to give mercury by the mouth. M. Martineau reports many cases in which he has been able thus to treat and cure patients who have been given up as incurable. The preparation employed by him was prepared by M. Delpech, the chemist, as follows:—Bichloride of mercury, 10 grammes; Catillon's dry peptone, 15 grammes; pure chloride of ammonium, 15 grammes. One gramme of this mercurial peptone represents 0.25 grammes of sublimate. This new product is employed as an injection in the following proportions. Solutions for hypodermic injections: Ammoniacal mercurial peptone, 40 centigrammes; distilled water, 30 grammes. This solution represents 4 milligrammes of sublimate to each injection of a syringeful containing 1 gramme and 20 centigrammes. It keeps for several days. The following is of a more stable composition: Ammoniacal mercurial peptone, 40 centigrammes; neutral glycerine, 36 grammes. The dose is the same. Dr. Martineau has treated, by these different formulæ, since April, about 172 patients. Beginning at first by injecting half a syringeful every day, equal to 2 milligrammes, he went on to inject 3, 4, and 5 milligrammes every day, up to as much as 10 milligrammes daily. The patients did not complain of any pain; there was no local reaction nor symptoms of salivation. By the mouth, he gives the following mixture: Ammoniacal mercurial peptone, 1 gramme; glycerine, 50 grammes; distilled water, 200 grammes. Each teaspoonful of this mixture represents 5 milligrammes of the sublimate. This preparation is thoroughly well tolerated by the stomach, but it does not act as rapidly and as certainly as the subcutaneous injection.

16. *Greslon on the Treatment of Sciatica by Hypodermic Injections of Nitrate of Silver.*—Dr. Greslon reports (*La France Méd.*, Sept. 26, 1881) the radical cure of a case of sciatica, which had resisted all ordinary methods of treatment, by hypodermic injections of the nitrate of silver. The patient, a lady 53 years of age, was of a gouty and rheumatic diathesis. She had recently suffered from several attacks of acute articular rheumatism. Her metacarpo-phalangeal articulations presented the characteristic deformities of arthritis deformans. In March 1879, the patient was attacked by sciatica in the left thigh and leg. The most severe pain was experienced in the calf and at the sacro-sciatic foramen. After unsuccessfully treating the case for twelve days with sinapisms, vesicatories, and anodynes, Dr. Greslon injected five drops of a twenty-five per cent. solution of nitrate of silver into the deeper tissues of the calf, at the most painful part. The injection was attended by violent pain, and followed by the formation of an abscess, which was opened at the end of a week. A few days later, the neuralgic pains had completely ceased in the leg. Eight drops of the same solution were then injected over the sacro-sciatic foramen. No abscess ensued, but an inflammatory exudation occurred, and discharged, six days after the puncture, some sero-sanguinolent matter. A week later, all pain had disappeared from the limb. The patient has had no relapse of the sciatica.

17. *Salomon on the Therapeutical Uses of Yerba Santa.*—Dr. Salomon reports (*New Orleans Med. and Surg. Jour.*, Nov. 1881) that yerba santa, or eriodyctum Californicum, has, in his hands, proved to be a remedy of value in bronchorrhœa, in acute bronchitis, in the cough of measles, and as a prophylactic against laryngismus stridulus. Dr. Salomon employed the fluid extract of the leaves, in doses of ten minims to one drachm, glycerine being the best vehicle, as water and syrups precipitate the gummy portion of the preparation. The author thinks that the remedy acts specifically on the mucous membrane

of the air-passages as an astringent. In chronic bronchitis, he was compelled, in the majority of cases, to abandon its use, and administer other remedies.

18. *Malherbe on Tartar-Emetic in Chorea.*—M. Malherbe of Nantes has published, in the *Jour. de Méd. de l'Ouest*, a paper tending to show that, notwithstanding the satisfactory results obtained by certain new remedies in chorea, tartar-emetic should retain an important place in the treatment of that disease. Emetic doses are quite sufficient. Thus administered, tartar-emetic produces its effects, especially in cases where the choreic spasm attains a high degree of intensity; and, if it do not always definitively cure, at least for a certain time it removes the danger. M. Malherbe recommends the simultaneous employment of large doses of morphia, either by the mouth or by hypodermic injection. For example, 10 or 15 centigrammes (1½ to 2¼ grains) of tartar-emetic should be given in the morning, and in the evening from two to four teaspoonfuls of syrup of morphia, or one, two, or three centigrammes of this substance in injection. This treatment was employed upon a girl aged 23 years, who had been affected with chorea for two years, and who came into the hospital with a severe recrudescence of all the symptoms, accompanied also by hysterical manifestations. An emetic draught of 15 centigrammes of tartar-emetic was prescribed, in the first instance, to be taken every five minutes; also a hypodermic injection of one centigramme of hydrochlorate of morphia, and an enema with four grains of bromide of potassium. The vomiting was copious; the second morning, the choreic movements had greatly diminished. The treatment was repeated two days afterwards, then at variable intervals; and the same improvement always occurred. The patient left the hospital, not cured, for her chorea seemed to become chronic, but much improved. M. Malherbe quotes this case because it clearly shows the powerful action of tartar-emetic on the choreic spasms. It was never necessary to administer the medicine for several days in succession. He also quotes the case of a young girl, in whom, notwithstanding the means employed, the disorder of the muscles had arrived at such a stage of violence that he had given directions to have a wadded case made to preserve the patient from the danger of external concussions. Two emetic doses of tartar-emetic, given at forty-eight hours' interval, assisted by large doses of morphia, seemed to have no effect; while, after a third emetic, a considerable soothing took place, and, at the end of three days, all choreic movement had disappeared.

19. *Tanret and others on Solutions of Caffeine for Hypodermic Injections.*—At a recent meeting of the Société de Thérapeutique in Paris (*Gaz. Hebdom. de Méd.*, Jan. 6, 1882), M. Tanret read a paper on this subject. He said that pure caffeine requires 93 times its weight of water for complete solution; therefore, up to the present time, it has not been generally employed in subcutaneous injections, one cubic centimètre of the liquid only containing little more than one centigramme of the active principle. The majority of the salts of caffeine proposed with this object, the acetate, valerianate, and lactate, become decomposed, in the presence of water, into free acid and caffeine, which is precipitated in consequence of its low degree of solubility. The salts containing mineral acids, sulphate, hydrochlorate, and hydrobromate, have little stability, and do not offer any advantage. M. Tanret has endeavoured to obtain a salt of caffeine by means of the chlorigenic acid which is associated with it in coffee, as Payen has demonstrated; unfortunately, the preparation of this salt is difficult and laborious. Since then, he has had recourse to similar acids, such as benzoic, cinnamic, and salicylic. He has thus been able to obtain double salts of caffeine and soda, having the advantage of being soluble in somewhat larger proportions, and having a constant composition. With double benzoate of caffeine and soda, a solution is prepared containing 20 centigrammes of alkaloid in a cubic centimètre; the solution of double salicylate contains from 25 to 30 centigrammes to the cubic centimètre. The solutions of benzoate and salicylate are generally alkaline, and are neutralised by means of the corresponding acid. These salts, however, have no great stability, for they decompose when the solution is treated with chloroform; and the caffeine, less soluble than the salt itself, is precipitated. M. Vigier believed that it is in consequence of an analogous decomposition of salts of narcotine contained in opium, that, by means of chloroform, ether, or turpentine, the so-called free narcotine is obtained. It differs in no respect from the so-called combined narcotine, which is similarly extracted from raw opium during the preparation of morphia. M. Dujardin-Beaumetz had used double benzoate of soda and caffeine in two cases, one of diphtheria, and the other of choleraic symptoms. He did not find any irritating local action from the solution prepared by M. Tanret for hypodermic injections; but, as to the therapeutic value of the drug, he could not yet form an opinion. M. Féréol asked whether the double salts of caffeine, proposed by M. Tanret, could not be administered by the mouth. M. Tanret replied that he had no other object in preparing so concentrated a solution of caffeine but for subcutaneous injections, but the double salts which he had obtained might be given as a draught. It would be enough to prescribe the dose of caffeine required, and to add to it a sufficient quantity of benzoate or salicylate of soda to obtain the complete solution of the alkaloid. An extemporaneous preparation of the double salt, containing a known dose of caffeine, might thus be easily obtained.

20. *Vigier on the Solution of Alkaloids in Oil or Glycerine.*—At a recent meeting of the Société de Thérapeutique (*Gaz. Hebdomade Méd.*, Jan. 6, 1882), M. Vigier pointed out the difference which exists, in a therapeutic point of view, between solutions of alkaloids in oil and in glycerine. It is true that the alkaloids dissolve more readily in glycerine; but, as scarcely any of this substance is absorbed by the skin, the preparation obtained is inert. On the contrary, oils dissolve alkaloids by means of the oleic acid in smaller quantity; but, the cutaneous absorption being more considerable, they yield much more manifest results.

21. *Stites on Ergot in Lead-Palsy.*—Dr. Stites of Belmont, Nevada, in a communication to the *Therap. Gaz.* (*Med. and Surg. Rep.*, Nov. 19, 1881), states that about fifty per cent. of a physician's practice in his locality consists of lead-poison cases. The greater part of the male population is at work in the silver mines, and liable to be affected by the lead contained in the silver ore. Wrist-drop is a very frequent symptom, and paralysis of other forms—even hemiplegia or paraplegia—is not an unfrequent complication. The milder manifestations of these symptoms are usually removed in a few days by

a cathartic dose of Epsom salts, followed by iodide of potassium. Persons who abstain from alcohol, keep their bowels open, and lead regular lives, are much less liable to suffer from lead-poisoning. In hemiplegia and paraplegia due to lead-poisoning, Dr. Stites finds that the combination of ergot and iodide of potassium yields extremely satisfactory results. He prescribes the following :—R. Potassii iodidi, ʒ ij; extr. ergotæ, fl. ℥j; extr. nucis. vomicæ, fl. ʒj; tincturæ cardamomi comp., ℥j; syrupi, q. s.; aquam ad ℥iv. A tablespoonful is given night and morning. He prefers the above to the iodide alone, or electricity, or tonics and nux vomica. Power is usually restored in a month. Under other treatment, recovery does not take place under three months. The efficacy of ergot is attributed to its effect on non-striated muscular fibre. No danger attends the therapeutic application of the drug.

22. *Ergotine in Pharyngitis.—La Revue Mens. de Laryngol.* points out a therapeutic method which is capable of giving good results in chronic pharyngitis with exaggerated development of the veins of the pharynx and muco-purulent secretion. The following lotion should be profusely applied, twice a day, over the pharynx by means of a camel-hair pencil: Ergotine, 15 grains; tincture of iodine, 1 drachm; glycerine, 1 ounce.

23. *Riopel on Collodion in Rheumatism.*—Dr. E. Riopel of Detroit (*Med. and Surg. Rep.*, Oct. 1881) alleges that he has found very good results from the external application of caoutchouc collodion in rheumatism. The collodion is painted over the affected part or parts, and is allowed to remain there for several days.

24. *Porter on Eruption from Oil of Tansy.*—Dr. G. L. Porter of Bridgeport, Connecticut (*New England Med. Jour.*, Oct. 15, 1881), reports an eruption caused by the ingestion of a drachm and a half of oil of tansy for abortifacient purposes; it markedly resembled variola. From the fact that there was a remote possibility of the patient having been exposed to small-pox infection, it was thought possible that this disease was the cause of the eruption. The premonitory symptoms, clonic convulsions, and the course of the eruption, were against this theory. The matter was finally set at rest by the confession of the patient. The dose is one of the largest non-fatal doses of oil of tansy on record.

25. *Lewin and Rosenthal on the Form taken by Chrysarobin in External and Internal Use.*—These writers have sought to ascertain whether chrysarobin undergoes in the organism an oxidation into chrysophanic acid (Virchow's *Archiv*, Band lxxxv, Heft 1). As means of recognition of chrysophanic acid, they employ the colour of the urine which, during the use of substances containing that acid (such as rhubarb, senna), appears greenish-yellow and changes to cherry-red, when the urine becomes alkaline or when caustic soda is added. Chrysarobin, extracted from araroba powder by means of hot benzol, was administered with bread-crumb to rabbits in doses of 1½ to 11 grains. On the following day, chrysophanic acid was proved distinctly present in both urine and fæces. That all the chrysarobin did not undergo transformation was proved by the fact that, in the course of the experiment, the rabbit got hæmaturia, a symptom never observed with pure chrysophanic acid. Only after fifteen days did the urine become free from albumen and chrysophanic acid. To test the change in external application, the writers shaved a considerable surface of a rabbit's skin, allowed any slight cutaneous lesions to heal, and then, with a camel's-hair brush, rubbed in for several days an ointment of chrysarobin (1 to 15). The part was then covered up, and on the fourth day chrysophanic acid was found in the urine, while, on the eighth day the urine contained albumen, and the animal died. The kidneys showed parenchymatous nephritis. Thus, in both cases, the same partial transformation into chrysophanic acid seems to take place, while the remaining chrysarobin seems to have the power of producing nephritis.

26. *Ribbert on the Effect of Tannic Acid on Albuminuria.*—Having, by compression of the renal artery of the rabbit for an hour and a half, induced an artificial albuminuria, Dr. Ribbert slowly injected into the jugular vein two to three cubic centimètres of a five per cent. solution of tannic acid (*Centralb. für die Med. Wissen.*, No. 3, 1882). He then examined the excised kidney, and found that the coagulated fibrin in the Malpighian corpuscles was distinctly less than in those where no tannic acid was used. Finding that this solution of tannic acid frequently caused coagulation of the blood and death, he employed a solution of two per cent. tannic acid neutralised with carbonate of soda, and of this he injected 25 cubic centimètres without causing any serious symptom. The albumen was now completely absent in most of the glomeruli, and in the others there was but a very narrow zone. This experimental result supports the use of tannin, as recommended by Professor Frerichs in nephritis. Dr. Ribbert would recommend the use of tannin and of tannate of soda in larger doses than has been customary; and, more especially, he would advise that they should be used early in the disease, while still, as he holds, confined to the glomeruli.

27. *Gutmann on the Action and Use of Aspidospermine.*—Dr. Gutmann records (*Archiv für Experim Pathol. und Pharmakol.*, Heft vi, p. 451) experiments with several preparations of this substance, the alkaloid of white quebracho bark. Four of these preparations were citrates, the fifth was the simple alkaloid. In frogs, the subcutaneous injection of 1-30th grain of the alkaloid caused distinct loss of voluntary power in the extremities, especially the posterior, going on to complete paralysis. The reflex action was less affected. To ascertain whether the effect was produced through the intramuscular terminations of the motor nerves, through the muscles, or through the central system, the common iliac artery and vein were tied; when it was found that the paralysis still followed, while also it was shown that muscular contractility was not diminished to direct faradic stimulation. The respiration was much retarded, probably the result of direct action on the respiratory centre, and ceased when paralysis was complete. The pulse sank from 38 to 15 in the half minute, a reduction which, it was shown by control experiments, was not due to the operation requisite for laying bare the heart. This result taking place in previously curarised frogs, Dr. Gutmann considers due, not to the action of the vagus, but to paralysis of the automatic cardiac ganglia. In rabbits, the respiration was not primarily affected, but the action on the heart was constant and characteristic, the pulsations sinking from 70 to 55 or 50 in the half minute. The temperature also fell, within an hour, 2 deg. to 2.7 deg. Cent. (3.6 to 4.8 Fahr.) Section of the vagi caused no increase in the frequency of the heart's beat. Sensation and motion were unaffected till death was near. Dr. Gutmann would, therefore, recommend aspidospermin in cases of cardiac neuroses and as

an antipyretic, for which last purpose cortex quebracho is used by the physicians of the Argentine Republic, where it is native. Dr. Gutmann calculates the minimum dose for an adult man as 18 grains. In a case of hemiepilepsy, by means of it he reduced the pulse from 80 to 60 per minute.

28. *Stadelmann on the Action of Toluylendiamin.*—Dr. Stadelmann has already detailed the results of his experiments with this drug on the dog (*Archiv für Experim. Pathol. und Pharmakol.*, Heft v, p. 287), results which may briefly be summed up in the statement that toluylendiamin, when administered to the dog, produces a well-marked 'absorption icterus'. He now gives the results of his experiments, with the same drug, on cats and rabbits (*Ibid.*, Heft vi, p. 422), and these, while interesting, are somewhat perplexing in the light of that already given. Administered to cats in doses of one to three grains, the drug, in 36 to 40 hours, produces an invariable and extremely marked hæmoglobinuria, while, in most cases, there is only the very slightest sign of icterus. When it is given to rabbits in repeated doses of seven grains, there is no hæmoglobinuria, and also very indefinite signs of icterus in a few cases. Although, in his experiments on cats, Dr. Stadelmann invariably found a few disintegrated blood-corpuscles in the urine, the condition was as different from hæmaturia as it well could be. The urine showed no trace of bile or bile-acids, but the secretion of bile in the liver and intestines was always free. The blood-serum contained a large amount of hæmoglobin dissolved in it. Dr. Stadelmann can offer no explanation of the apparent anomaly, discussing various theories only to reject them after experiment.

29. *Donath on the Physiological Effects and Chemical Reactions of Chinoline.*—This writer continues (*Berichte der Deutsch. Chem. Gesellsch.*, No. 14, 1881, p. 1769) his account of the properties of chinoline as an antipyretic and antiseptic. Using Buchholz's cultivating fluid (10 parts of sugar-candy, 1 part of tartrate of ammonia and half a part of phosphate of potash, in 100 parts of water), he found that a solution of chloride of chinoline effectually prevented the formation of bacteria. Also, a solution of even 0.2 per cent. prevents lactic acid fermentation; but, on the other hand, even 5.0 per cent. has little or no effect on yeast-fermentation. Quinine, also, in 2.0 per cent. solution, has no effect in preventing yeast-fermentation. Of the list of reactions of chinoline, the following may be mentioned. 1. With caustic potash, it falls milky white, with difficulty soluble in excess of potash; so, also, with carbonate of soda and ammonia. 2. With iodide of potassium and iodine (7 parts of the first to 5 of the second in 100 parts of water), it produces a reddish-brown precipitate, insoluble in hydrochloric acid. 3. With picric acid, it gives a yellow amorphous precipitate, soluble in alcohol and potash. 4. Mercury chloride gives a white flocculent precipitate readily soluble in hydrochloric acid. 5. Ferrocyanide of potassium colours the solution red, and, on addition of a mineral acid, a reddish-yellow precipitate falls. Experiments with chinoline have shown that it may be given in daily doses of 15 to 30 grains without bad effects, allowing, therefore, its use as an internal antiseptic. It has no such albumen-precipitating action as carbolic acid. Chinoline is not excreted in the urine as such, but is probably transformed into a piridincarbonic acid.

30. *Gnauck on the Action of Hyoscine.*—Following up his experiments on the action of hyoscyamine, Dr. Gnauck has sought to determine the action of hyoscine, one of the elements of hyoscyamine (*Centralbl. für die Med. Wissensch.*, No. 45, 1881). His experiments were mainly performed on healthy individuals and on patients affected with nervous diseases. Commencing with small doses of iodide of hyoscine in healthy individuals, he found that hyoscine is tenfold stronger in its effects than hyoscyamine, approaching thus more nearly to atropine. The effects observed were cerebral oppression, vertigo, glimmering before the eyes, feeling of intoxication, thirst, nausea, acid taste, itching of skin and a feeling of heat, laboured and retarded respiration, reddening of the face, dilatation of the pupils, unsteadiness of gait and delirium—that is, the same symptoms as those from atropine and hyoscyamine, also exhaustion and sleep, as with hyoscyamine. In addition, however, there was also a retardation of the pulse even with large doses—a result not seen with atropine and hyoscyamine. This last symptom varied with the amount of the dose and the susceptibility of the individual. Even a very minute dose (1-600 grain) of hyoscine invariably produces some of its effects, and subcutaneously twice as powerfully as by the mouth. The interval elapsing is usually from 2 to 12 minutes, or slightly longer by the mouth, and the effect is very various in different individuals. The fall in the pulse is the first symptom to appear, the last to disappear, ranging from 8 to 20 beats. A slight reduction of the pulse appears in the beginning of the action of atropine and hyoscyamine, and with small doses; but this is quickly followed by paralysis of the terminal filaments of the vagus. Hyoscine probably causes the fall in the pulse by an irritation of these filaments; tropaic acid, the other element in hyoscyamine, therefore, having the power to alter its action. Dr. Gnauck promises to detail, at a future time, the results of experiments on patients affected with mental diseases.

31. *Beetz on Iodoform Insufflations in Laryngeal Phthisis.*—This writer (*Berl. Klin. Woch.*, No. 2, 1882) gives details as to his method of applying this remedy. Iodoform, finely powdered by rubbing up with ether, may be applied to the larynx by insufflation with so little irritation that the morphia at first added can very quickly be omitted. The amount used, 30 grains daily, in three or four applications, is not enough to cause toxic symptoms. To prevent, as far as possible, annoyance from the odour of the remedy, an inhalation of carbolic acid solution may be given before the insufflation; a proceeding which will also allow the more direct application of the remedy to the ulcerated surface, although Dr. Beetz has found the iodoform alone to succeed admirably.

JAMES ANDERSON, M.D.

MEDICINE.

RECENT PAPERS.

1. KINNICUTT.—Transient Albuminuria. (*New York Med. Record*, 1882, p. 17.)

2. CHARCOT.—The Phenomena Produced by the Application of the Galvanic Current to the Cranial Vault during the Hypnotic Lethargy of Hysteria. (*Prog. Med.*, 1882, No. 2.)

3. WHITNEY. — Disease of the Pancreas. (*Boston Med. and Surg. Jour.*, Dec. 22, 1881.)

4. VARIOT.—Malarial Hepatitis. (*Le Prog. Méd.*, 1882, No. 3.)

5. DUMONTPALLIER. — On Hypnotism. (*Le Prog. Méd.*, 1882, No. 3.)

6. NOTHNAGEL.—Physical Examination of the Fæces (*Zeitschr. für. Klin. Med.*, Band iii.)

7. TRIPIER.—Diarrhœa in Cancer of the Stomach. (*Lyon Méd.*, Oct. 16, 1881.)

8. MAYER. — Scarlatina with a High Temperature. (*Annales de Méd. d'Anvers.*)

9. LODI.—Acute Icterus from Partial Primary Atrophy of Liver. (*Rivista Clin. di Bologna*, March 1881.)

10. DU CASTEL.—An Epidemic of Ecthyma in a Small-Pox Ward. (*Jour. de Méd. et de Chir. Prat.*, Dec. 1881.)

11. VERGELY.—Angina Pectoris in its Relation with Diabetes. (*Bull. Gén. de Thérap.*)

12. MEUSNIER.—The Influence of Pneumo-Hydrothorax on the Course of Pulmonary Tuberculosis. (*Gaz. des Hôp.*, Sept. 24, 1881.)

13. FINNY. — Rheumatic Fever with Pericarditis and Hyperpyrexia treated by the Cooling Pack. (*Brit. Med. Jour.*, Dec. 1881.)

14. DENAND.—Forms of Fever in Tuberculosis. (*Jour. de Méd. et de Chir. Prat.*, Oct. 1881.)

15. WAGNER.—Occult Septicæmia. (*Deutsches Archiv für Klin. Med.*, Band xxviii.)

16. TRIPIER.—The Adult Cephalic Murmur in the Orbital Region. (*Revue de Méd.*, Oct. 1881.)

17. MAHOMED.—Direct Transfusion of Blood for Hæmorrhage in Typhoid Fever. (*Brit. Med. Jour.*, Dec. 1881.)

18. DE CASTRO. — Disease of the Bronchial Glands. (*Med. Times and Gaz.*, Dec. 1881.)

19. ANNINGSON.—Perforating Ulcer of the Stomach, leading to Medico-Legal Inquiry. (*Brit. Med. Jour.*, Dec. 1881, p. 982.)

20. FOOT. — Hiccough Lasting Twenty-six Weeks. (*Ibid.*, Dec. 1881, p. 983.)

21. GRADENIGO.—Auscultation of the Eye. (*Gaz. Med. Italiana*, Oct. 29, 1881.)

22. SILVESTRI.—A Case of Intestinal Paralysis with Obstinate Constipation. (*Gaz. Med. Italiana*, Nov. 12, 1881.)

23. LYNCH.—The Differential Diagnosis of Cardiac and Pericardial Murmurs. (*Cincinnati Lancet and Clinic.*)

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1. *Kinnicutt on Transient Albuminuria.*—Dr. Kinnicutt (*New York Med. Record*, 1882, No. i, p. 17) read a paper before the New York Academy of Medicine, in which he drew attention to the occurrence of transient albuminuria, to which attention had been directed by Gull, Johnson, Saundby, Moxon, and others. His own observations seemed to show that temporary albuminuria, as it occurs in children and adults in apparent health, may be traced, in a large number of instances, to a transient oxaluria or lithuria, and he suggested that the sequence of events in the causation of albuminuria is as follows: 1. The temporary presence of a large amount of imperfectly oxygenated matter in the circulation; 2. Disturbance of the general nervous system, in which the vaso-motor system of the kidney shares, or one confined to the vaso-motor system of the kidney in its elimination of these products of a faulty digestion; 3. A transient dilatation of the blood-vessels in the kidney, and a retardation of the blood-current in the glomerular vessels, with possibly consequent alteration in the functions of the glomerular epithelium, also of a temporary nature. In the discussion which followed, Dr. A. Jacobi said that he regarded these cases of albuminuria as due to a diseased state of the vessels analogous to purpura. Dr. W. H. Thompson had seen several cases of albuminuria in children dependent on malaria and cured by quinine. Dr. E. Bradley referred to cases of temporary albuminuria occurring in young persons addicted to the excessive use of cigarettes.

2. *Charcot on the Phenomena produced by the Galvanic Current applied to the Cranial Vault during the Hypnotic Lethargy of Hysteria.*—M. Charcot (*Le Prog. Méd.*, 1882, No. 2), in a recent communication to the Biological Society of Paris, referred to his previous observations on the neuro-muscular excitability of hypnotised patients (LONDON MEDICAL RECORD, 1881, p. 221), and would now add to that description certain phenomena which indicated a superexcitability of the cerebral motor centres. He had found that when a galvanic current was applied to the side of the head of a patient in the state of hypnotic lethargy, it produced movements of the muscles on the opposite side of the body, whilst no such effect followed if the patient were aroused. Then movements occurred only at the opening or closing of the current. These phenomena had been observed in five patients.

3. *Whitney on Disease of the Pancreas.*—Dr. W. F. Whitney (*Boston Med. and Surg. Jour.*, Dec. 22, p. 592) presented a communication to the Suffolk District Medical Society, entitled, 'Four Cases of Disease of the Pancreas'. The first was a case of cancer in a widow, aged 55, who presented the symptoms of severe pain in the abdomen, diarrhœa with bloody stools, vomiting, and, later, constipation. Some months afterwards, a hard pulsating tumour could be felt in the left hypochondrium. The necropsy revealed cancer of the entire pancreas, with secondary deposits in the liver. The other three cases were of hæmorrhage into the organ. In the first case, the symptoms were all acute, and death followed rapidly. In the second, the patient, a man past middle life, suffered from 'colic' and 'jaundice'. He was very yellow, with epigastric pain, loss of appetite, and lassitude. The case terminated with symptoms of peritonitis. Near the centre of the pancreas, there was a wedge-shaped brownish-black nodule, and several smaller ones were situated in the head, and one in the tail. Microscopically, they showed the characters of infarctions. In the third case, there was extensive purulent infiltration and sloughing, 'resulting, probably, from hæmorrhage'. In the discussion which followed, Dr. Prince mentioned a case of hæmorrhage into the pancreas, which was characterised by collapse, cold sweats, tender and swollen abdomen, and pulselessness. At the necropsy, the head of the pancreas lay in a pool of pus, and there was evidence of recent hæmorrhage and peritonitis. One week before the attack, the patient had complained of severe abdominal pain after turning a somersault. [There is no mention of the state of the urine.—*Rep.*]

4. *Variot on Malarial Hepatitis.* — M. Variot (*Le Prog. Méd.*, No. 3, 1882) reports a case of liver-disease occurring in the ward of M. Reynaud, at La Charité Hospital. The patient, a woman aged 41, had been in South America, where she had suffered from malarial fevers; and, since her return to France, in 1881, had been troubled by frequent diarrhœa, vomiting sometimes after every meal, and, on two occasions, she had had an attack of jaundice, without, however, any special pain in the hypochondrium. On admission, she looked jaundiced; but her urine, though high-coloured, gave no green colour with iodine or nitric acid. She presented obvious physical signs of pulmonary phthisis; her liver extended for two finger-breadths below the costal border. The abdomen was a little distended. After death, extensive disease was found in the lungs. The liver weighed 78 ounces; it was of normal shape and smooth surface, yellow, slightly hard, but easily broken by the finger. Its cut surface was of the same yellow colour, but dotted with

brighter yellow spots of the size of a pea, and very confluent. The gall-bladder and ducts were healthy, and the latter quite permeable. The spleen was large and soft, weighing 10 ounces. On microscopical examination, the liver-cells were found to be very fatty and pigmented; there was considerable increase of connective tissue, no melanosis, properly so called, and no particular increase of the biliary ducts. [It seems very doubtful whether this can be fairly regarded as a case of malarial hepatitis.—*Rep.*]

5. *Dumontpallier on Hypnotism.* — M. Dumontpallier (*Le Prog. Méd.*, No. 3, 1882) brought before the Société de Biologie certain experiments made by him on a hysterical patient. During the hypnotic sleep, this patient did not present the phenomena of muscular superexcitability. Rendered cataleptic by opening the eyes, she became a sort of automaton, in whom certain groups of muscles might be made to contract by directing a fine jet of air by means of a small India-rubber apparatus upon the cranium; and it was possible to determine the relation of particular points on the cranium to particular muscular movements. M. Dumontpallier regarded the phenomena as reflex. In the discussion which followed, M. Charcot pointed out that this observation differed essentially from the class of phenomena he had brought before the society at its previous meeting. In his cases, there was always neuro-muscular superexcitability, a definite objective condition. His patients were in a state of lethargy, in itself fundamentally distinct from catalepsy, while the movements produced were only at the opening and (above all) at the closing of the current.

ROBERT SAUNDBY, M.D.

6. *Nothnagel on the Physical Examination of the Fæces.*—This author considers the macroscopic and microscopic examination of human stools more important than the chemical, and has carried it out in 800 cases, arriving at certain results (*Zeitsch. für Klin. Medicin.*, Band iii), of which we give the following. 1. Small round scybalous masses are not necessarily the result of intestinal stricture, but may be caused by paralysis of the peristaltic action of the colon allowing their formation in the pouches of the colon. 2. The reaction is mostly alkaline, but in infantile diarrhœa, frequently acid. 3. The colour is not caused by bile-pigment, which is not found in normal stools, but is present in the greenish-yellow stools of children and in the yellow mucus particles seen in the stools of adults. 4. Various lime-salts are found microscopically in the stools, but none of clinical importance. 5. Undigested food is also found in the fæces. Starch-granules are rare, even where the food is a plentiful starch-diet. They occur in larger quantity, however, in the stools of convalescents from typhoid fever. Muscle-fibres are commoner than starch-granules, being evidently more difficult of digestion. 6. Mucus appears either as distinct masses or intimately mixed with the fæces, and detected only by the microscope. 7. Cylinder epithelium appears frequently; but round cells, such as are seen in the bronchial secretion, are comparatively rare. 8. Blood and the eggs of intestinal parasites appear frequently, the blood, although apparently fresh, being almost always disintegrated.

JAMES ANDERSON, M.D.

7. *Tripier on the Adult Cephalic Murmur in the Orbital Region.*—Tripier (*Revue de Méd.*, Oct. 1881) adds some new observations on this subject, which may be regarded as a supplement to his previous paper, an abstract of which appeared in the LONDON MEDICAL RECORD for April 1881. Since the appearance of that paper he has had three cases of chlorosis, three of metrorrhagic anæmia, one (a male) of anæmia from frequent hæmatemesis, and one (also a male) with cachectic anæmia without apparent cause. The result of these new observations is that Tripier finds that the position of maximum intensity is not on the temples, but in the orbital region. His method is to cause the patient to close the eyelids, and then auscultate with the stethoscope on the globe of the eye, or directly, with a cloth between the patient's eye and the ear. The latter he finds more easy and useful than mediate auscultation. Tripier has seen no reason to modify his opinion that the murmur is not propagated from the heart, and he thinks that its position of greatest intensity points to the conclusion at which he previously arrived, viz., that the murmur is produced near the end of the internal carotid artery. G. A. GIBSON, M.D.

8. *Mayer on Scarlatina with a High Temperature.*—M. Mayer publishes, in the *Annales de Méd. d'Anvers*, the report of a case in which he was called to see a patient whom he had chloroformed two days previously for the extraction of a tooth. He found an intense fever with an axillary temperature of 40 deg. Cent. (102 deg. Fahr.). From the evening to the next morning this patient had had severe lassitude, headache, and an intense pain in the throat. On the evening of the same day the temperature rose to 41.5 deg. Cent. (106.7 deg. Fahr.) and the pulse to 130. The next morning, after a very restless night, the temperature was 43 deg. Cent. (109.4 deg. Fahr.). Having the idea of an exanthematic action, and remembering cases in which hyperthermia had prevented the appearance of the exanthem, M. Mayer resolved to lower the temperature by the application of bladders containing ice. Cold baths could not be given, on account of the very great weakness of the patient. The neck and nape were therefore surrounded with these bladders; others were placed on the chest and the abdomen. The patient was at first relieved; the temperature fell to 42 deg. Cent. (107.6 deg. Fahr.); and, at his request, the ice was replaced with cold water. The temperature then rose to 43 deg. The ice was replaced, and during the night the thermometer fell again, to rise at the end of the following day to 43 deg. But at this moment the commencement of the eruption appeared, and gradually became characteristic, and the ice was finally stopped. The disease, though developing itself as a sharp attack of scarlatina, followed a normal course; the desquamation appeared about a fortnight later. As the reporter remarks, without the thermometer, of which the exactness was verified on this occasion, he would not have conceived all the exanthematic nature of the mischief, would not have justly valued the gravity of the disease, and would not have dared to apply with so much energy the refrigeration to which he attributes the successful termination of this dangerous affection.

9. *Lodi on Acute Icterus from partial Primary Atrophy of the Liver: Recovery.*—Dr. J. Lodi reports the following case in the *Rivista Clinica di Bologna*, March 1881. Angelo Magnoni, aged 42, of a strong constitution, had never suffered from a similar disease to that which Dr. Lodi records, and had always inhabited slightly malarious places. For some years, however, he superintended in the summer and autumn a rice plantation on the left bank of the Po; notwithstanding this, he had never had intermittent fever, and showed no sign of paludal poisoning.

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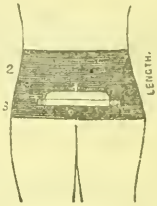

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In the beginning of October 1879, while he was superintending the rice-harvest, he was seized with a slight rigor throughout the body, headache, weakness, and want of appetite. He had to walk about a mile and a half to reach his home. The shivering soon ceased, and was not followed by great heat. During two days the patient did not feel anything else; the headache, weakness, and want of appetite increased. On the fourth day there was copious epistaxis, which recurred on the following day. Finally, he lost blood by vomiting and by stool, and became so weak that he was obliged to keep his bed. Being now called to see the patient, Dr. Lodi found a condition of coma, delirium, decided icterus, and cold skin, particularly in the extremities; the pulse was 66, respiration 16, temperature 36 Cent. (96.8 Fahr.) The lungs were healthy. There was a systolic murmur, having its maximum at the apex. The liver was greatly diminished in size; percussion showed its limit to be, on the left, at the level of the right edge of the sternum; the upper edge at the nipple-line under the seventh rib; below, it did not reach the edge of the false ribs by four centimètres (about 1½ inches). No portion of the liver could be found in the space between the umbilicus and the xiphoid apophysis. In percussing somewhat strongly the hepatic region referred to, the dulness terminated by becoming changed into an almost tympanic sound. On pressing the ribs from below upwards, the patient felt slight pain. The spleen was slightly enlarged. The urine contained biliary pigment in abundance, and traces of albumen and blood. The abdomen was slightly depressed, but revealed nothing abnormal on palpation or percussion. The patient was subjected to a stimulant treatment (wine, coffee, etc.) The symptoms, after having persisted for some days, diminished by degrees; the temperature increased, the brain became clear; the icterus and thirst, and the small size of the liver, continued still for some time. Soon the liver increased at the rate of 1 centimètre daily. In ten days it had recovered its normal dimensions. From that time Dr. Lodi lost sight of the patient, but three months afterwards he met him again in perfect health. Dr. Lodi makes the following remarks on this case. This man was profoundly icteric. This icterus had the clinical form of acute icterus, in consequence of the serious cerebral disturbance and the copious hæmorrhage which accompanied it, and also of the enormous diminution of the liver, and the swelling of the spleen. All the other viscera were healthy, and the patient had enjoyed excellent health up to the time of his illness. The idea of destruction of the liver, consecutive on cirrhosis by stasis or any other chronic affection of this viscera, could not be entertained. Dr. Lodi also rejects the idea that the case was one of catarrhal angiocolitis, followed by consecutive atrophy of the liver, secondary acute hepatitis of calculous origin, primary hepatitis ending in suppuration, acute steatosis, or typhoid icterus; and concludes that there was therefore rapid atrophy of the hepatic parenchyma, accompanied with more or less fever. This disease is usually accompanied by serious cerebral and general disturbance. Graves, Griffin, Budd, Schnitzler, in Oppolzer's medical wards, and Bamberger, have published similar cases. More recently, Valdayer (Virchow's *Archiv*, Band xlii) and Klebs (*Handbuch der Path. Anat.*, Band i), in studying anatomical lesions of the liver in acute atrophy, have observed in the connective stroma of the hepatic acini, in the midst of a mass of cells formed by the morbid processes, a formation of epithelial cells, which they both agree in taking for a regeneration of the hepatic tissue.

10. *Du Castel on an Epidemic of Ecthyma in a Small-Pox Ward.*—M. Du Castel (*Journ. de Méd. et de Chirurgie Pratiques*, Dec. 1881) observed this complication in the patients in the small-pox wards under his care at the Saint Antony Hospital. The ecthyma supervened either during the stage of desiccation or even that of suppuration. The ecthymatic eruption, sometimes discrete, sometimes confluent, chiefly occupied the anterior surface of the chest and the upper or lower limbs. It was also seen on the face: generally it showed itself in successive eruptions, sometimes preserving a mild character, sometimes, on the contrary, terminating in death. For a long time the men of the ward only showed numerous cases of ecthyma, but a majority of the convalescents were attacked by it. It was only after several months that the disease broke out in the women's ward, where it broke out with the same intensity. Before acknowledging its contagious nature, M. Du Castel waited for the development of the disease in other wards; but the isolation of the small-pox patients scarcely allowed contact with other wards. Nevertheless, the house-surgeon of the ward and a male nurse were attacked by ecthyma, localised in the one in the hand, and in the other in the feet, and probably produced by direct contact with the patients. His own and M. Vidal's experience has well demonstrated that ecthyma is inoculable. But it may be said in connection with inoculable ecthyma, that there is no doubt contagious and epidemic ecthyma; this variety would be so much the more important to recognise, because, when it finds a soil appropriate for its implanting, such as convalescent small-pox patients, it may become a serious and even mortal affection. The local treatment consisted in lotions of carbolised oil on the face, and lotions of mercurial sublimate over the rest of the body.

11. *Vergely on Angina Pectoris in its Relations with Diabetes.*—M. Vergely of Bordeaux read a memoir on this subject, at the meeting of the Academie de Médecine de Paris on Nov. 29 (reported in the *Bull. Gén. de Thérap.*), in which he postulated the following conclusions. 1. Attacks of angina pectoris may show themselves in the course of diabetes. 2. Attacks of agina pectoris may be simple or associated with intermittent neuralgia. 3. They may manifest themselves independently of any cardiac affection. 4. It is advisable, in presence of an attack of angina pectoris, to carefully examine the urine to make sure that this neurosis or neuralgia is not connected with diabetes.

12. *Meusnier on the Influence of Pneumo-hydrothorax upon the Course of Pulmonary Tuberculosis* Dr. Paul Meusnier of Blois communicates to the *Gaz. des Hôp.*, Sept. 24, 1881, a case of pulmonary tuberculosis, the progress of which he considers to have been retarded by the supervention of pneumo-hydrothorax. This fortunate result he attributes to the compression of the diseased lung, by which suppuration was limited and septic poisoning prevented. In July 1879, Dr. Meusnier first saw the patient, a young man aged 20, who had had phthisis a year. The disease was confined to the left lung, and had advanced to the stage of excavation. The general condition was bad, the cough incessant, and the expectoration purulent. Emaciation was extreme. A daily hectic paroxysm occurred. No change took place in the symptoms until September 27th, when perforation of the lung occurred, and pneumo-hy-

hothorax was developed. After the disappearance of the dyspnœa and pain incident to the perforation of the lung, marked amelioration of all the symptoms was manifested. The cough and fever disappeared, and the general health improved. The patient gained three kilogrammes (six and a half pounds) every two weeks, and in February weighed more than ever before in his life. Improvement continued until May 1880, when, after exposure, the pleuritic effusion greatly increased. On June 8th, thoracentesis was performed, and two litres (three and a half pints) of pure serum withdrawn. The fluid reaccumulated, and assumed a purulent character. Septic fever now reappeared, and the patient died suddenly, before thoracentesis could be again resorted to. [See an abstract of a paper on the same subject by Dr. Hérard, in the London Medical Record for August 1881, p. 306.]

13. *Finny on Rheumatic Fever, with Pericarditis and Hyperpyrexia, treated by the Cooling Pack.*—In the *Brit. Med. Jour.*, Dec. 1881, p. 932, Dr. J. Magee Finny reports a case where, after several days' treatment, a woman, aged 37, had a temperature of 107.2 deg., and a pulse of 136. The symptoms being urgent, she was gradually stripped, from above downwards; and towels, wrung out of iced water, were assiduously applied, one after another, first to the head and neck, then over the thorax and abdomen, and lastly over the thighs and legs. By the time the last cloth was applied, the first had become warm and was changed, and so on with each towel. In ten minutes the temperature fell to 103.8 deg., and the pulse to 120 deg. In a few hours the temperature was 100.4 deg.; pulse 92 deg.; and from that time the progress was uninterrupted, the pericarditis also rapidly disappearing. The chief interest of the case lays in the instantaneous relief afforded, by the cold applications, to severe symptoms attending the hyperpyrexia. The assiduous application of towels, wrung out in cold water, has many advantages over cold immersion. It can be done at once, and anywhere, and without assistance. It does not alarm either patients or friends, and is not attended with any fatigue to the patient, besides allowing the reduction of temperature and pulse to be more easily noted.

14. *Denand on Forms of Fever in Tuberculosis.*—M. Denand says (*Jour. de Méd. et de Chir. Pratiques*, Oct. 1881) that, in tuberculoses, there may be distinguished an invasion fever, a softening fever (*fièvre de ramollissement*), and an ultimate fever, due to the absorption of the septic products of the pulmonary cavities. The invasion fever is the most important with regard to diagnosis and treatment. It may be confounded with slight typhoid fever, with gastric affection, or with so-called growing fever in young persons. It is distinguished by its persistence, its irregularities, and its suspicious antecedents. There are differences, according to the form of phthisis which it accompanies. In acquired phthisis, the lungs show a remarkable intolerance of tuberculosis; the fever developes itself with intensity even before the local lesions may be taken notice of; it is acute and tenacious. The exacerbations more frequently occur in the morning or in the day. In acute phthisis, there is acute and persistent fever. Manifest remissions may sometimes simulate an intermittent fever. The febrile maxima show themselves frequently: in the morning the type is the reverse of that of the evening. In tubercle of the joints, there are present febrile symptoms, at more or less distant intervals from the outset, and there are frequent paroxysms in the morning. It does not show that characteristic of continued persistence which is met with in the common forms; more or less prolonged disappearance, followed by sudden reappearance corresponding to the stage of softening, or to congestive accidents. Notwithstanding emaciation, patients frequently retain an animation and activity to which, in fact, the fever itself may, perhaps, contribute. In scrofulous phthisis, the fever is not very intense, and, during a great portion of the day, is non-existent; the exacerbations are moderate, and occur towards the evening. High temperature is very rare. Sulphate, or, better still, hydrobromate of quinine, is very suitable for the fever of invasion. It should be administered three hours before the febrile attack. Small doses, from 25 to 60 centigrammes (about 4 to 9 grains), should be administered at first; later on, from 0.60 centigrammes to a gramme (about 9 to 15½ grains may be given; but then the quinine will act rather by removing the congestion of the lungs as a vaso-motor. Arsenic is a valuable antifebrile agent in the prolonged forms of the disease.

15. *Wagner on Occult Septicæmia.*—Leube, in 1878 (*Deutsch. Archiv fur Klin. Med.*, Band xxviii, p. 521; and *Siècle Méd.*, Nov. 28, 1881), called attention to two cases of septicæmia, which he termed cryptogenetic; that is to say, of which the origin was unknown, or could not be discovered. These cases, which are confounded with the most various diseases, are not absolutely rare. Wunderlich, in 1857, described some cases as 'primary pyæmia'. Schützenberger of Strasburg spoke of cases of this kind to his pupils, and specially recommended minute examination of the hairy scalp in doubtful cases of acute fever. Professor Wagner reports 19 cases, of which some were really curious; and he also arrives at the same conclusions as his predecessors; that is, that septicæmia (or septico-pyæmia exists, and is more frequent than is believed, but it is frequently mistaken in consequence of the ignorance of symptomatology. It is, therefore, the symptomatic description which is the weak point. It is formulated by Dr. Wagner as follows. 1. The general condition is serious. There is a febrile state, suddenly apparent, rarely preceded by a regular rigor, but attended with much shivering, and very often with severe rheumatoid pains of the bones and joints. 2. The patient experiences so much discomfort, that he is obliged to take to his bed at once, or, at the latest, after some days. 3. There is violent fever of the remittent or intermittent type, but always irregular. The exacerbations generally assume the aspect of a severe rigor. 4. The pulse is very frequent, generally dicrotic. 5. There is frequency of respiration, which cannot be explained by the mere elevation of the temperature, and which, in the majority of cases, is connected with serious affections of the lungs or pleura. 6. There is hypertrophy of the spleen, with scarcely any appreciable increase in the size of the liver. 7. There is more or less marked abdominal meteorism, often accompanied by intestinal borborygma, occasionally by frequent fluid stools. 8. There is moderate albuminuria, rarely tube-casts or blood-corpuscles in the urine. 9. There is a pustular or papular cutaneous exanthema, with a hæmorrhagic base. 10. Icterus is rarely intense. 11. Subjective and objective symptoms are met with in the large articulations and the long bones, especially rheumatoid pains, occasionally attended with swelling or redness of the joints. 12. Serious cerebral symptoms occur, such as obnubilation, delirium, convulsions, and coma. 13. The progress of the affection

is rapid. 14. Medicinal treatment by quinine, the salicylates, etc., is unsuccessful. The affections with which septico-pyæmia may be confounded are, more especially, typhoid fever, of which the progress is very much less rapid and less tumultuous, and which is never accompanied by icterus or exanthema similar to those described, nor by joint-lesions; miliary tubercle, which it is almost impossible to diagnose; and epidemic cerebro-spinal meningitis, which presents, perhaps, still greater difficulties, since the rapidity of the progress, and the presence of an exanthem, can no longer be considered as means of diagnosis. In this case, inquiry must be made into the presence of an epidemic meningitis. The question is still further obscured by the fact that the wound, which theoretically should always be present, does not always exist, and that, in place of it, there may be internal suppuration, necessarily overlooked, because it does not give rise to any characteristic symptom. Finally, in a certain number of cases, rare, it is true, it has been absolutely impossible, notwithstanding the most minute researches, and notwithstanding the certainty that pyæmia existed, to find any starting-point. The question, therefore, remains obscure, notwithstanding its importance, and still requires much research.

16. *Tripier on Diarrhœa in Cancer of the Stomach.*—A paper by Dr. Tripier of Lyons (analysed in the *Lyon Méd.*, Oct. 16, 1881) is intended to show that the theories of Trousseau and Brintoris, on the method of production of diarrhœa in cancer of the stomach, are incapable of accounting for all the facts, and that the conditions under which diarrhœa is noted are very variable. He gives the following results of an analysis of 28 cases of cancer of the stomach in which there was a *post mortem* examination. In more than half of the cases, the patients had diarrhœa, which supervened sometimes at the outset of the disease, sometimes during its course, in a more or less transitory manner, but most often during the months preceding death. It may, also, only appear during the last days of the illness: in almost every case it alternates with constipation, or is consecutive on it. Diarrhœa is met with wherever the cancer may be located, whether the tumour be ulcerated or not, and even with a certain amount of stricture of the pylorus, whether there be any or no complications, but especially when the patients take a notable quantity of food. Constipation or abnormal motions may be observed in conditions apparently identical with those which produce the diarrhœa. Hence the diarrhœa in cancer of the stomach cannot actually be explained by a determinate anatomical condition. It therefore seems rational to suppose that it is most frequently produced through impaired function of the seriously diseased stomach, or by irritation, having for its starting-point gastric lesion, and of which the action makes itself felt on the various constituent portions, not only of the stomach, but of the whole digestive canal. The diet will be the determining cause. Diarrhœa may supervene at variable periods more or less distant from the termination of the disease, and even at its outset. Constipation is also probably produced by phenomena of irritation, but especially when the patients eat little or vomit what they eat. The pathogenesis of these various conditions cannot be indicated in a more precise manner than in the majority of cases of dyspepsia, in which we see sometimes constipation, sometimes diarrhœa; sometimes these troubles alternating, without their immediate cause being evident. Finally, there is also a colliquative diarrhœa, of which the immediate causes are not thoroughly known. As diarrhœa is not only an ultimate symptom in cancer of the stomach, and as it may show itself at all periods of the disease, even when it is not distinctly characterised, errors of diagnosis may result from overlooking this clinical indication, and subsequently from attributing the assemblage of symptoms to some other disease in which diarrhœa plays an important part. M. Tripier, in confining his memoir to the facts he has observed, points out the possible confusion of cancer of the stomach, more especially with pulmonary tuberculosis, and incidentally with progressive anæmia and interstitial nephritis.

17. *Mahomed on Direct Transfusion of Blood for Hæmorrhage in the Course of Typhoid Fever.*—Dr. F. A. Mahomed relates, in the *Brit. Med. Jour.*, Dec. 1881, p. 939, two cases of typhoid fever in which transfusion of blood was performed. One lived five days, the other nine. Dr. Mahomed calculated that transfusion would save one in seventy cases. The mode preferred was that adopted by Dr. Aveling. An interesting discussion followed the reading of the cases, relative to the best instruments for transfusion.

18. *De Castro on Disease of the Bronchial Glands.*—Mr. James C. De Castro, speaking of some cases of this disease (*Med. Times and Gaz.*, Dec. 1881, p. 707) describes one where fatal hæmoptysis ensued from a suppurating gland, in which the coats of a rather large pulmonary vessel were involved. Three cases of disease of the glands are detailed, and give a very instructive view of these obscure, and often mistaken, affections.

19. *Anningson on Perforating Ulcer of Stomach leading to Medico-Legal Inquiry.*—Dr. Anningson reported to the Cambridge Medical Society (*Brit. Med. Jour.* Dec. 1881, p. 982) a case in which a man, aged 40, had died under suspicious circumstances. The corpse was exhumed one month subsequently to burial. The stomach was carefully spread out on a piece of glass, and the cause of death asserted to be ulcerative perforation of that organ. According to Virchow, the cause of such ulcers is a block in one of the gastric veins, depriving the part of nutrition.

20. *Foot on Hiccough lasting Twenty-six Weeks.*—In the *Brit. Med. Jour.*, Dec. 1881, p. 983, Dr. A. W. Foot details the history of a lad, aged 15, whom he was called to see after he had been hiccoughing, without ceasing, except during sleep, from Nov. 5, 1880 to April 9th, 1881. The attack came on quite suddenly. He had previously suffered from shorter attacks on two occasions. A month's treatment with hemp and iodoform cured the patient. The average rate of the hiccoughing was 840 per hour, and it lasted, without intermission, except during sleep, for twenty-six weeks. RICHARD NEALE, M.D.

21. *Gradenigo on Auscultation over the Eye.*—Professor Gradenigo (*Gaz. Med. Italiana*, Oct. 29, 1881) is induced to believe from experiments extending over some considerable time, that, in auscultation over the eye-ball, a means of clinical diagnosis exists which may become important. In his paper he describes and explains the sounds heard on auscultating over the orbit and globe. As a practical point he recommends the use of a stethoscope, *ad hoc*, consisting of an India-rubber tube attached to a wooden cone, shaped so as to fit exactly over the closed lids. The hand which steadies the instrument should also be covered with some non-conducting material, such as a glove or a piece of wadding.

22. *Silvestri on a Case of Intestinal Paralysis with Obstinate Constipation.*—The patient, whose case is described by Dr. R. Silvestri in the *Gaz. Med. Italiana*, Nov. 12, 1881, was a blacksmith, aged 62, who had previously at intervals suffered from obstinate constipation. During one of these attacks, two years before his death, there had been no movement of the bowels for ten days. On the present occasion, he exhibited no serious symptoms until the seventh day, when the pulse rose to over 100; the abdomen became slightly tympanitic, and pain was felt in the epigastric region. From this date until the ninth day, when he died, the attacks of pain became more intense and frequent; the urine was lessened in quantity, and vomiting, but not of fæcal matter, was more or less constant. The necropsy showed that the viscera generally were healthy, save that the colon, at a point extending from the lower fifth of its transverse portion down to the rectum, was enormously dilated. Its walls were also considerably hypertrophied. This large cavity was distended with gas, but otherwise empty. The diseased portion was distinctly marked off from the healthy, both by an increased thickness of tissue and by a redder tint. The proximate cause of death was considered to be acute peritonitis, due to check in the fæcal circulation. This was itself caused by paralysis of the descending colon, the result of chronic inflammation of that viscus. This diagnosis was confirmed by the mildness and subacute character of the symptoms during the first days of the attack, and by the absence of any tumour, of tympanites, or of acute pain. Should the author meet with and recognise a similar case during life, he considers that treatment by means of electricity would probably afford the most satisfactory results. One reophore should be placed on the false ribs of the left side, the other in the rectum. L. Forbes.

23. *Lynch on the Differential Diagnosis of Cardiac and Pericardial Murmurs.*—At a meeting of the Medical and Chirurgical Society of the State of Maryland (*Cincinnati Lancet and Clinic*) Dr. J. Lynch presented a paper in which he gave a new point in the differential diagnosis of cardiac and pericardial murmurs. The following paragraph explains his method. 'Whenever the friction-murmur is produced at or near the heart's apex (the only condition in which there will be any serious difficulty in the diagnosis), if we cause the patient gradually and slowly, but entirely, to inflate the lungs, we will perceive that the friction murmur becomes progressively more intense until the act of insufflation is complete. Now make the patient hold his breath while the lungs are in this state of complete insufflation, and the murmur will be steadily maintained at its maximum intensity. Cause him then to expire in a like slow and gradual manner, and the murmur will be found to decline in intensity until the minimum will be reached at the completion of the expiratory act, at which it will be maintained until another inspiration increases its intensity. The murmur does not entirely disappear, however. It is present at all stages of respiration, but always presenting the variation in its intensity.'

Dr. Kimdrat of Graz has been appointed Professor of Pathology in the University of Vienna, in the room of the late Professor Heschl.

Professor Panum has been chosen to preside at the next meeting of the International Medical Congress, which will be held in Copenhagen.

SURGERY.

RECENT PAPERS.

1. Suris.—Peritoneal Surgery. (*Brit. Med. Jour.*, Dec. 1881, pp. 925, 971.)

2. Shuttleworth.—A Case of Multiple Exostoses. (*Ibid.*, p. 976.)

3. Norton.—A New and Reliable Operation for Webbed Fingers. (*Ibid.*, p. 931.)

4. Reeves. — Mid-Femoral Osteotomy for Knock-Knees and Bow-Legs. (*Ibid.*, p. 935.)

5. Hayes.—Radical Cure of Hydrocele by Iodoform. (*Ibid.*, p. 936.)

6. Harrison.—Tapping the Bladder through the Prostate. (*Ibid.*, p. 1010.)

7. Main.—Antiseptic Surgery. (*Ibid.*, p. 1013.)

8. Hahn.—Operative Treatment of Floating Kidney by Fixation. (*Centralbl. für Chir.*, 1881, No. 29.)

9. Hewson.—The Treatment of Whitlow. (*Coll. and Clin. Record.*)

10. Le Dentu.—Stretching the Lingual Nerve in Tic Douloureux. (*Jour. de Méd. et de Chir. Prat.*, Dec. 1881.)

11. Le Dentu.—Case of Large Hydronephrosis: Incision: Urinary Fistula: Extirpation of Kidney. (*L'Union Méd.*, Nov. 17.)

12. Herrick.—Lupus Exedens successfully treated by Creasote and Calomel. (*Med. Annals.*)

13. Heath, W. H.—The Heatonian Method for the Cure of Hernia. (*Buffalo Med. and Surg. Jour.*, April 1881.)

14. Grayhill. — Symmetrical Spontaneous Gangrene in a Child. (*Virginia Med. Monthly*, Aug. 1881.)

15. Byrd.—Ulceration and Perforation of the Vermiform Appendix treated by Abdominal Section. (*Virginia Med. Monthly*, Aug. 1881.)

16. Demono and Polaillon.—Modified Tibio-Tarsal Resection in certain Cases of Compound Fracture of the Ankle. (*Bull. de l'Acad. de Méd. de Paris.*)

17. Corazzi.—A Case of Herniotomy in Simulated Hernia. (*Gaz. Med. Ital.*, Nov. 12, 1881.)

18. Gallardo.—Suborbital Neurotomy. (*Siglo Méd.*, Nov. 21, 1881.)

19. Sacerdoti.—Rupture of Bladder and Urethra successfully Treated by External Urethrotomy. (*Gaz. Med. Ital. Prov. Ven.*, Nov. 19.)

20. Marocco.—Treatment of Specific Inguinal Adenitis. (*Ibid.*, Dec. 3.)

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1. *Sims on Peritoneal Surgery.*—Dr. J. Marion Sims, in the *Brit. Med. Jour.*, Dec. 1881, pp. 925, 971, gives some admirable remarks upon this subject, especially in reference to gun-shot wounds, in order to answer the pressing question, 'Does the recent progress of peritoneal surgery lead to a better treatment of gun-shot wounds of the abdomen?' Ovariotomy is the parent of peritoneal surgery, and the principles necessary to success in all peritoneal operations were formulated by Mr. Spencer Wells at the late International Congress, thus: 1. All hæmorrhages must be promptly controlled by pressure, ligature, or hæmostatic forceps; 2. The peritoneal cavity must be thoroughly cleansed after operation, before closing the abdominal incision; 3. The abdominal incision must be properly closed. Dr. Sims, after reviewing all the operations requiring abdominal section, expresses his belief that the day will soon come when, in all gun-shot wounds, and in all cases of perforation of the bowels from ulcers and other causes, we shall not hesitate, under proper conditions, to open the abdomen, clean out the peritoneal cavity, pare the edges of the wound, and bring them together with sutures, treating the case

as we now treat other cases of wounded peritoneum. Lives may thus be saved that must otherwise quickly ebb away.

2. *Shuttleworth on a case of Multiple Exostoses.*—Dr. G. E. Shuttleworth, in the *Brit. Med. Jour.*, Dec. 1881, p. 976, reports the remarkable case of an imbecile lad, aged 13, in whom at least sixty growths from, and enlargements of, bones in different parts of his body could be counted. A tabular view of the two sides of the body is given, and, in many instances, the symmetrical development of the growths is most marked.

3. *Norton on a New and Reliable Operation for Webbed Fingers.*—Mr. Arthur A. Norton, in the *Brit. Med. Jour.*, Dec. 1881, p. 931, illustrates, with a plate, the operation he has found to succeed in cases of webbed fingers. As it can only be understood by a reference to such plate, we must refer our readers to the original article. By the means suggested, Mr. Norton asserts that this, which is one of the most troublesome and unsuccessful of operations, is converted into one of the most simple and most certain of success.

4. *Reeves on Mid-Femoral Osteotomy for Knock-Knees and Bow-Legs.*—In the *Brit. Med. Jour.*, Dec. 1881, p. 935, Mr. H. A. Reeves describes the seventh of a series of cases in which he has divided the femoral shaft just below its middle, and easily corrected serious deformities arising from knock-knees and bow-legs. Mr. Reeves prefers this operation for the following reasons. 1. The bone is divided in its narrowest part, and, therefore, the operation is most easily done. 2. The deformity is easily corrected, and a large ugly-looking callus avoided above the joint, a necessary result of supracondyloid osteotomy. 3. The effusion into the joint, frequently following this latter mode of operating, is avoided. 4. Recovery is more rapid, because the extent of injury requiring repair is reduced to its minimum. 5. Frequent repetitions of osteotomy are done away with; the section in the middle of the bone, at the point of junction of the two curves, correcting the double deformity of knock-knee and bow-leg. Mr. Reeves performs 97 per cent. of his osteotomies without antiseptic precautions.

5. *Hayes on Radical Cure of Hydrocele by Iodoform.*—Mr. P. J. Hayes speaks most favourably of the results when iodoform is passed into the sac after the fluid is removed (*Brit. Med. Jour.*, Dec. 1881, p. 936). But little pain is experienced, and the patient need not be confined to his room.

6. *Harrison on Tapping the Bladder through the Prostate.*—Mr. Reginald Harrison, in the *Brit. Med. Jour.*, Dec. 1881, p. 1010, describes an operation that he has found most valuable in some exceptional cases of retention due to hypertrophy of the prostate. A special trocar and cannula is required, and is introduced in the median line of the perinæum, three-quarters of an inch in front of the anus, and pushed steadily through the prostate into the bladder. A piece of India-rubber tubing is then attached to the cannula, to convey the urine into a vessel during sleep, which tubing, during waking hours, is clamped, and only loosened when the patient needs to micturate.

7. *Main on Antiseptic Surgery.*—Dr. Wm. Main, in the *Brit. Med. Jour.*, Dec. 1881, p. 1013, recurs to the now much debated question as to the use of the spray. Dr. Main suggests that the carbolic acid does not act by destroying the vitality of the germs, experiments proving that bacteria will thrive in very strong solutions of carbolic acid, but that the current created blows them away from the wound, and that, therefore, the force of this current should be lateral to drive germs away from, and not directed from the front so as to drive germs into, the wound.

Richard Neale, M.D.

8 *Hahn on the Operative Treatment of Floating Kidney by Fixation.*—Considering that the extirpation of the kidney is in itself a serious operation, and that, moreover, by the removal of the one kidney an increased function is thrown on the other possibly defective kidney, surgeons will welcome the new method recommended by the above writer (*Centralb. fur Chir.*, 1881, No. 29). He has already practised it in two cases of floating kidney (the right in both cases), completely relieving all symptoms in one case, and greatly alleviating the other, where the left kidney was also slightly movable. The patient lying on his left side, a vertical incision is made along the outer edge of the erector spinæ from the twelfth rib to the crest of the ilium, dividing the latissimus dorsi and quadratus lumborum muscles. The kidney, in its fatty capsule, is then pressed from the abdominal side into the wound, and there fixed with six to eight catgut sutures. Both cases recovered without a bad symptom. Since in both cases the kidney became, after a time, again slightly movable, the operator recommends that the fatty capsule should be opened, separated from the kidney, and firmly sutured into the wound, while, also, the kidney should be fixed as low down as it can possibly be drawn.

James Anderson, M.D.

9. *Hewson on the Treatment of Whitlow.*—Dr. Addinell Hewson offers some suggestions for the accurate diagnosis and successful treatment of whitlow (*Coll. and Clin. Record*). For diagnosis, he makes a flattened conical tube of binder's board, with its base $5 \times 3\frac{1}{4}$ inches in diameter, so trimmed as to fit closely over brow, cheeks, and upper lip. The length is such as to bring the apex at about the distance of the range of distinct vision. The apex is an orifice $\frac{1}{8} \times \frac{3}{16}$ inch in diameter. The tube is made from a sheet of binder's board, by dipping in warm water to soften it, then rolling it diagonally, and wrapping with cord to retain form until dry. By means of this simple apparatus he examines the tissues by transmitted light. In the case of a suspected whitlow, the patient's finger is brought to the point of the tube, which is held in the direction of a bright light, either natural or artificial, while the face is so applied at the base as to make it fit closely and exclude the light. During the examination, Dr. Hewson finds it of advantage to have the patient practice forced, rapid respiration, to produce an anæsthetic effect. If the apex of the tube cover healthy tissues of the finger, the characteristic bright pinkish-red colour is readily perceived; while, if the tissues be engorged, the darker red tint, deepened in proportion to the intensity of the engorgement, will be equally characteristic, and will form a marked contrast to the colour to be seen on examining the corresponding finger on the other hand. If the tint, though still reddish, be a yellow hue, pus has formed in the cellular tissue around, or in the theca of the tendon. If by making firmer pressure, so as to cut off the lateral illumination through the tissues, the tint be found to be of a positive yellow, it is evident that there is suppuration in the theca of the tendon. Finally, if the tint so transmitted be of a dirty or opaque yellow, the bone or periosteum is the seat of purulent formation and collection. When such examination demonstrates that pus has not yet formed, he has generally succeeded in aborting a whitlow by

the application of a thick paste of wet clay, covered first with tissue paper, and then with a thin layer of bandage stiffened by liquid glue painted in strips lengthwise on each side of the finger. The object of applying the glue thus, instead of covering the whole surface, is to allow the drying of the clay, which would be prevented by coating the whole surface with glue. Dr. Hewson's experience with such uses of clay has been very extensive, and he reports some very interesting and valuable results obtained by this agent. In this class of cases here considered, he finds that, as a rule, the relief is very prompt, in which case the dressing is allowed to remain for several days. When the pain is not relieved in two or three hours after the application of the earth, he removes it at once, and makes a free incision, as he feels sure that nothing else will arrest the process.

10. *Le Dentu on Stretching the Lingual Nerve in a Case of Tic-Douloureux.*—M. Le Dentu (*Jour. de Méd. et de Chir. Pratiques*, Dec. 1881) has performed stretching of the inferior lingual nerve in an elderly female, who for several years had an extremely violent tic-douloureux of the face. The pain ceased rapidly, and has not since re-appeared. The traction on the nerve was moderate; for, on the one hand, serious trophic troubles might be expected to follow the operation, and, on the other hand, M. Charcot has related a case in which death rapidly supervened.

11. *Le Dentu on a Case of Large Hydronephrosis: Incision: Urinary Fistula in the Groin: Extirpation of the Kidney.*—M. Le Dentu read recently (*L'Union Méd.*, Nov. 17) a paper to the Paris Academy of Medicine, in which he related that in March 1875 he was called to a man aged 22, who had a fluctuating swelling of the flank and of the iliac fossi of the left side. There were hydronephroses and perinephritic abscess. The acute suffering of the patient decided M. Le Dentu to make an incision in the swelling at its softest point. A clear liquid escaped from it, which soon became mixed with blood. At the end of some days, urine began to flow abundantly from the wound. This flow persisting, and frequently bringing on inflammatory outbreaks, and the patient's life being in danger, M. Le Dentu proposed extirpation of the corresponding kidney. The operation was performed on April 14th. The kidney, which was easily removed from its capsule, had become degenerated in the upper two thirds, and converted into a pouch with flaccid walls. It was normal in the lower third; the hilus was enlarged. A catgut ligature was applied over the healthy portion of the kidney, and a second ligature was placed in a convenient situation, by means of a Cooper's needle, and drawn tight by forceps. M. Le Dentu excised with scissors all the portion which lay beyond the ligatures, leaving a sort of stump. Lister's dressing was used during some days, until the parts which had sloughed through the application of the ligature and the thermo-cautery were eliminated. The patient was very weak, with pulse between 120 and 145; temperature, 38 to 39.5 cent. (100.4 deg. to 103.1 deg. Fahr.) The lumbar wound progressed regularly towards cicatrisation, which was complete at the end of two months. The fistula in the groin, which M. Le Dentu had slit up and enlarged with the galvanic cautery, suppurated profusely during a fortnight; but, from the first day, the flow of urine was entirely suppressed. So far, the cure was completed at once. At the time when the case was reported, the fistulous track, in which M. Le Dentu had kept a drainage-tube, only yielded a few drops of purulent serosity; the urinary functions were perfect, and the patient, a distinguished dramatic artist, was able to make a brilliant reappearance at the commencement of October. The first nephrectomy ever performed in France was done by M. Le Fort, and was unsuccessful. This case of M. Le Dentu's is the first instance of cure by nephrectomy recorded in France.

12. *Herrick on Lupus Exedens Successfully Treated by Creosote and Calomel.*—Dr. Clinton B. Herrick reports the following case in the *Medical Annals*. P. S., aged 65, was admitted into the Albany Hospital (service of Dr. A. Van Derveer) October 21, 1880, with the following history. There was no trace of disease of an ulcerative nature in his family. About fifteen years previously, the patient first noticed a small wart, about the size of the head of a pin, in the front of the left ear. It remained about the same for a period of five years; then it began to be a little sore, and, if scratched, would bleed, a scab forming afterwards. He also noticed then that a small ulcer was progressing, which increased and spread downward, and then toward his eye, the ulcer healing and crusting over in its track. The character of the sore was in form irregular, without discharge, up to this time, and painless; being accompanied, however, with an intense itching sensation, so great sometimes that the patient could scarcely control himself. The disease advanced, surrounded the eye, implicated the lids, and crept on over the left side of the nose down to the alæ, and a portion on the right side. About three months before coming into hospital, the ulcer began to discharge very profusely a thin purulent matter. When admitted, the disease covered almost entirely the upper half of the left side of the face. At first, creasote alone was applied, then dichloracetic acid was used with some benefit. Then applications were made of creasote and calomel, and from the first use of it the ulcer began to improve. The method of using it was to take a camel's hair pencil, dip it first in the creasote, then in dry powder of calomel, applying it to the edges and where depressions existed, the brush with a twirling motion dislodging and removing the cells. Under this treatment, the surface glazed over with healthy skin, its size diminished, and at the time of the report there only remained a small portion of the disease over the eyelids, without any indications of returning.

13. *Heath on the Heatonian Method for the Radical Cure of Hernia.*—Dr. W. H. Heath (*Buffalo Med. and Surg. Jour.*, April 1881) says that the radical cure of hernia has in all ages attracted the attention of surgeons, but hitherto without the success the importance of the cure would lead us to hope. All of the older methods have justly fallen into disrepute, and no sound surgeon would practice either of them with any confidence. Accordingly, the Heatonian method may be considered more hopeful for these reasons: 1. The almost complete absence of danger; 2. The great encouragement held out by the results; 3. Its sound pathology. This operation has not been in the hands of the profession more than four years; and it is well known that the inventor was ostracised by the profession for keeping his discovery a secret, but to do him justice it should be stated that he originally intended to make his discovery common property, but was so ill treated by those whom he invited to witness some of his operations, that in his disgust he determined to keep his method of cure to himself. The pathology of this operation consists in developing by the action

of an irritant, which is also an astringent, a tendinous irritation, causing a contraction of the fibrous tissues and rings, which the circular arrangements of the fibres makes possible, and the formation of strongly plastic lymph. It being recognised that the fibrous structures and rings are the tissues primarily and principally at fault, to these alone is the remedy addressed. The reason why the irritation set up in the inguinal canal is not so serious as to be dangerous is this. The structures are not vascular to an extent that would render the irritation likely to communicate itself to the peritoneum. The irritant is mild, consisting of the fluid extract of quercus alba, prepared *in vacuo*, to which is added the solid extract of the same tree at the rate of 28 grains to the fluid ounce, and morphia to lessen the pain; and the operation is subcutaneous. The permanency of the effect is due to the interstitial and hyperplastic changes, and to the disposition of fibrous tissues to recover slowly. The instrument used is a device of Dr. De Garmo, being a 20-minim syringe, having a screw piston to deposit the contents gradually, and a trochar-needle, by which its point is guarded while in the inguinal canal. Stronger solutions may be used in cases of very old hernia, and very patulous canals. For the operation, the patient, having had the bowels moved by oil the day previously, is placed in bed, and the hernia and sac, if possible, reduced. The presence of the sac does not prevent a successful result, but it does diminish the effect. The operation consists in determining the exact position of the external abdominal ring, by invaginating a finger of the right hand in the scrotum, and fixing its position on the exterior by a finger of the other hand, which is made to press directly down upon it, or, if possible, in it. The instrument already prepared is carried with a sharp thrust quickly through the integument, just passing the external pillar of the ring; the needle then guarded is carried on into the canal, care being exercised not to injure the spermatic cord, or penetrate into the peritoneal cavity. The position of the point of the instrument should now be verified by the finger invaginated through the scrotum, and the irritant should be deposited as the syringe is withdrawn, all the fibrous structures being wet. A bandage and compress previously applied should now be carefully adjusted in the proper position, and so arranged that the compress shall bear with considerable firmness in the direction of the canal, with greater pressure over the external than over the internal ring. But little pain follows the injection. Tenderness exists in some degree for a time, but not enough to require removal of the compress. The recumbent position for a week and strict confinement of the bowels must be insisted on, for the hernia should not be allowed to descend after the operation. The bandage or a light truss should be insisted on for a month; after that, the truss may be removed, and the case considered cured. In a certain number of cases, the operation will have to be repeated where the canal is large and patulous, or where the hernia is the result of violence, and has torn away one or both rings; or again, in congenital hernia, where there seems to be a deficiency of fibrous structure. This operation, though simple, requires considerable care and dexterity. The spermatic cord may partially overlie the sac, which may be irreducible. The direction of the canal and the position of the internal ring may be changed. The possibility of transfixing one of the pillars, of wounding the spermatic cord, or of entering the abdominal cavity, are all to be remembered and avoided. Attention to every detail in operating, adjusting the compress and bandage, and the after-care, are so important as to largely determine the result in most cases. A little time in the dissecting-room with a long needle will serve to familiarise the beginner with the points to find and to avoid. The author has operated twelve times with one failure and one accident. Nine cases were permanently cured, and two cases were still under observation.

14. *Grayhill on Symmetrical Spontaneous Gangrene in a Young Child.*—Dr. Grayhill, of Amsterdam, Virginia, reports a case of gangrene occurring in both legs of a young child, aged 2½ years, during convalescence from a mild attack of scarlatina (*Virginia Med. Monthly*, Aug. 1881). The mother had been carrying him around, holding him by the legs and thighs, and, when she sat him down, he began to cry and complain of his legs. By evening he was very fretful, and the legs and feet were swollen and discoloured, so that the physician was called. He found both legs and feet swollen and discoloured up to within two or three inches of the knee-joint; cool, and very sensitive to the touch. A week later, lines of demarcation were visible, and a cadaverous odour was noticeable. Sloughing was complete in four weeks, symptoms of pyæmia having developed once only, and for a few days, during the time. The bones were now taken off, and in four months the child was perfectly well. The treatment was tonic, stimulant, and disinfectant. The cause was supposed to be embolism.

15. *Byrd on Ulceration and Perforation of the Vermiform Appendix Treated by Abdominal Section.*—Dr. William A. Byrd, of Illinois, who advocated the above-mentioned treatment in a paper read before the American Medical Association in 1880, reported an interesting case of the kind at last year's meeting (*Virginia Med. Monthly*, Aug. 1881). The patient, a married woman, had been suffering symptoms of obstruction and suppuration for several days before Dr. Byrd saw her, the difficulty having begun nine days previously, with colic pains in the region of the cæcum. When he saw her, March 27, he diagnosed inflammation and obstruction of the bowel at the cæcum; but, as she was now a little easier, he was not allowed to operate until April 1. The cæcum and appendix were inflamed and ulcerated throughout, with several perforations and adhesions, the cause for which condition appeared to be several hard concretions found in the abscess-cavity. The perforations were all cut into a single opening, the edges of which were stitched to the opening in the abdominal walls, making an artificial anus about three inches in diameter. An opening was left at the side, through which the abdominal cavity was washed every few hours during the treatment of the case, with a very weak solution of carbolic acid. The usual hygienic, quieting, and supporting treatment was given; and, at the time of the report, one month later, she had been improving, with promise of being entirely well in a short time. This was Dr. Byrd's twenty-second abdominal section, the fourth in which he also opened into the bowel, all the latter resulting in cure. He gives much credit to the washing out of the peritoneal cavity, and to the artificial anus. He insists that the operation should be done before inflammation sets in.

16. *Demons and Polaillon on Modified Tibio-Tarsal Resection in Certain Cases of Compound Fracture of the Ankle.*—At a recent meeting of the Paris Académie de Médecine, M. Polaillon read a report on a case of M. Demons, surgeon to the Saint

André Hospital of Bourdeaux, who reported that he had performed a similar operation to that communicated by M. Polaillon to the Academy at their meeting of September 20th. The case was one of fracture of the two bones of the left leg, near the tibio-tarsal joint. There was a transverse wound at the level of the inner malleolus. The articulation was opened, the inner malleolus torn away; the upper fragment of the tibia projected through the wound; the fibula was fractured two finger-breadths above the outer malleolus; the foot was turned outwards. M. Demons performed tibio-tarsal resection. The articulation was opened widely by an incision made along the lower extremity of the tibia. He detached and completely removed the fractured tip of the internal malleolus, and then resected the upper fragment of the tibia. He afterwards made a vertical incision along the fibula, and resected the two fragments, leaving the outer malleolus *in situ*. The astragalus was intact. The upper cartilaginous layer was removed with the scissors and mallet. Lister's dressings and immobilisation were employed. The patient was cured, his foot was straight and firm; there is only a tendency to turn the foot on the outer edge in walking. M. Polaillon acknowledged that M. Demons' operation was anterior to his; but the priority, in reality, must be referred to M. Richet; and, perhaps, if all the cases of tibio-tarsal resection published in France and other countries were analysed, it would be found that before M. Richet, some other surgeon, finding the peroneal malleolus intact, had conceived and executed the project of leaving it attached to the astragalus; but this conception, if it had existed, had not been generally made known until M. Richet put it into practice in 1874. M. Polaillon further remarked that M. Demons' case was of extreme interest, because it confirmed the utility of the preservation of the external malleolus in resection of the lower extremity of the two bones of the leg.

17. *Corazzi on a Case of Herniotomy in Simulated Hernia.*—Dr. Lodovico Corazzi describes, in the *Gaz. Med. Italiana*, Nov. 12, 1881, the case of a woman aged 63, who, before coming under his care, had already, for fourteen years, been the subject of an inguinal hernia on the right side. Without any apparent cause, this suddenly exhibited signs of strangulation, which did not decrease even after the hernia had apparently been reduced by taxis. The sac was, therefore, opened; but, even after this, reduction could not be effected. Uncertain whether or not he had reached the intestine, Dr. Corazzi continued his incisions, with the final result of giving exit to a quantity of fluid and gas. These he took to be the contents of the intestine itself, which he supposed he had wounded; and further operative interference was, therefore, desisted from. The necropsy, made a few hours after death, revealed, instead of strangulation, a perforation of the small intestine about two yards above the ileo-cæcal valve. The contents had become extravasated in the abdominal cavity. Thus, what was supposed during the operation to be intestine, was really the sac; the fluid and the gas it contained were derived, the one from a peritoneal exudation, the other from the intestine itself, which had ruptured much higher up at the seat of an ulcer. A correct diagnosis in such a case was almost an impossibility. There would really seem to have been no strangulation whatever; all the patient's symptoms having been directly due to perforation and consequent peritonitis. The simultaneous existence of a hernia was merely an accident, which, however, from its nature, was calculated to induce an error of diagnosis.

18. *Gallardo on Suborbital Neurotomy.*—Dr. Gallardo (*Siglo Medico*, Nov. 21, 1881) narrates a case of cure of neuralgia of the infra-orbital nerve by division, after various other forms of treatment had failed. The patient had, at the date of writing, been free from all pain for four months. The author considers that only such cases of neuralgia as are of peripheral, as opposed to constitutional origin, should be subjected to operative interference. Some indication of the probable success of an operation may be gathered from the conduct of such forms of neuralgia under local treatment, such as hypodermic injections. Should these fail to give relief, the disease is probably of constitutional origin, and an operation is contraindicated.

19. *Sacerdoti on a Case of Rupture of Bladder and Urethra Successfully Treated by External Urethrotomy.*—The patient, whose case is reported by Dr. Sacerdoti in the *Gaz. Med. Italiana Prov. Venete*, Nov. 19, was a boy aged 13, who fell across a beam of wood, striking, in the first instance, his perinæum. When seen, the objective symptoms were great discoloration over the inguinal, scrotal, and perineal regions, a wound on the inner and upper portion of the left thigh, and a globular tumour in the suprapubic region. No urine could be passed, though the desire to do so was very great. On pressing the tumour, urine could be made to flow out of the wound in the thigh; but following up the track most carefully, the author could not, nevertheless, reach the bladder, nor could he enter it *per urethram*. Taking these and other symptoms into consideration, he believed he was in presence of a case of ruptured urethra and bladder, with extensive extravasation of urine. He, therefore, performed external urethrotomy, introducing, on the second day, a catheter to draw off the urine as secreted. On the eighth day, an abscess opened at the seat of the wound in the thigh, but gradually all adverse symptoms disappeared, and two months after the operation the urethral fistula had healed, and the patient was discharged completely cured. Antiseptic treatment was adopted throughout.

20. *Marocco on a New Method of Treatment of Specific Inguinal Adenitis.*—Dr. Cesare Marocco's method of treatment (*Gaz. Med. Italiana Prov. Venete*, Dec. 3, 1881) consists essentially in excision of the infected glands. He considers such a treatment to be especially indicated when adenitis has changed into periadenitis, and when the neighbouring tissues have become boggy, and form, as it were, a focus of suppuration. The presence of pyrexia, and of general constitutional disturbance, is no bar to the operation. This is simple, consisting merely in enucleating the diseased glands, stanching the flow of blood, and bringing the edges together with sutures. The author gives an analysis of five cases treated by the above method. The duration of treatment varied from twenty-two to fifty-three days. In no instance did any complications arise after the operation. [This method of treatment is not particularly new. An analysis of all the cases gives an average of thirty-three days to each, which cannot be considered a very brilliant result.—*Ref.*]

Litton Forbes.

PATHOLOGY.

RECENT PAPERS.

1. Strauss.—Cardiac Hypertrophy in Renal Disease. (*Arch. Gén. de Méd.*, Jan. 1882.)

2. Lukjanow.—Functional Disturbances of Single Cavities of the Heart. (*Centralbl. fur die Med. Wiss.*, No. 49, 1881.)

3. Cayla.—Tuberculosis of the Fallopian Tubes. (*Le Progrès Méd.*, 1882, No. 1.)

4. Dale.—The Infection of Phthisis. (*Lancet*, Dec. 1881, p. 1108.)

5. Mayor. — Renal Lesions in Pregnant Women. (*Revue Méd de la Suisse Romande.*)

6. Sanders.—Hæmorrhage into the Ventricles of the Brain. (*Amer. Jour. of Med. Sciences*, Oct. 1881.)

7. Key.—Recurrent Retrobulbar Medullary Sarcoma: Metastases in the Sub-dural Space of the Brain and Spinal Cord. (*Hygeia*, 1881; and *Nord. Med. Arkiv*, Band xiii.)

8. Albert. — Congenital Deficiency of Part of the Tibia. (*Allgem. Wiener Med. Zeitung*, No. 27, 1881.)

9. Baumgarten.—The Transformation and Proliferation of the Epithelium of the Intestinal Lymphatics. (*Centralbl. fur die Med. Wiss.*, No. 3, 1882.)

10. Langhans. — The Formation of Cavities in the Spinal Cord as a Result of Interruption to the Circulation. (Virchow's *Archiv*, Band lxxxv.)

11. Rosenberger.—The Nature of the Septic Poison. (*Centralbl. fur die Med. Wiss.*, No. 4, 1882.)

12. Namverk.—Contributions to the Pathology of the Brain. (*Deutsches Archiv für Klin. Med.*, Band xxix.)

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1. *Strauss on Cardiac Hypertrophy in Renal Disease.*—Dr. L. Strauss (*Arch. Gén. de Méd.*, Jan. 1882) has ligatured the ureter in rabbits, and has found as a result hydronephrosis and hypertrophy of the left ventricle. He refers to the clinical observation of Potain, that cardiac hypertrophy follows nephritis secondary to obstacles to the flow of urine. He gives two cases of hypertrophy of the heart, following obstruction of the ureter from cancer of the uterus. These facts appear to point to the conclusion that a lesion primitively and exclusively renal can determine cardiac hypertrophy.

2. *Lukjanow on Functional Disturbance of Single Cavities of the Heart.*—Lukjanow, at the suggestion of Professor Botkin of St. Petersburg, has undertaken (*Centralb. fur die Med. Wiss.*, 1881, No. 49) a series of experiments on dogs and rabbits, to determine whether the harmonious working of the heart as a whole may be prevented by occlusion or ligature of the coronary arteries, by stoppage of the respiration, or by occlusion of the aorta or pulmonary artery. He summarises the results as follows. 1. The occlusion of one coronary artery affects first the side supplied by it, then the other side, and primarily influences the auricle. 2. Occlusion by clamping causes changes in the number and character of the contractions; the ligature differs only in producing the effect sooner. 3. Changes in the number and character do not always proceed equally. 4. Inequality in the contractions of the auricles is produced much more easily than of the ventricles. 5. The contractions of the auricles and ventricles may easily be made to be unequal in number; also the two auricles may be readily made to contract at different rates, but it is much more difficult to obtain this result with the ventricles. 6. Between the regular cardiac contractions and the irregular oscillation of muscular fibres, there is an intermediate stage of peristalsis which may run through the heart quite regularly; the heart's muscle is capable of peristalsis and antiperistalsis. 7. While the auricle is contracting regularly, but the ventricle, in consequence of occlusion of a coronary artery, shows only peristaltic movements, irritation of the peripheral end of the vagus affects the movements of the auricle, but not those of the ventricle. 8. The secondary frog's thigh contractions, which in a normal heart are manifested by all its cavities, are enfeebled by clamping a coronary artery, chiefly on the side supplied by it; most frequently secondary contractions are not retained under these circumstances, an explanation of which is not afforded either by alterations in the number and energy of the heart's contractions, or by changes in the frog's thigh. 9. At a certain stage of the clamping of the left coronary artery, the left auricle shows marked congestive phenomena. 10. The alterations produced by occluding a coronary artery may disappear completely on the clamp being removed, with restoration of the heart's function. 11. The conus arteriosus, as regards its function, is in certain degrees independent. 12. Sudden asphyxia affects sometimes most the right heart, sometimes the left; but the phenomena are not the same as those produced by occlusion of the coronaries; amongst other things, there is no decided tendency to peristalsis, and a less rapid influence on the secondary contractions. 13. The influence of coronary occlusion appears to be very probably attributed to two principal factors; first to the more or less sudden and complete ischæmia; second, to the retention in the heart of the waste products produced by its continued contraction for some time after the occlusion.

3. *Cayla on Tuberculosis of the Fallopian Tubes.*—M. A. Cayla (*Le Progrès Méd.*, 1882, No. 1) reports the case of a young woman, aged 22, who was admitted under Dr. Moutard-Martin, apparently in good bodily health, and with no history of serious illness or hereditary tendencies, but who sought relief from nervous attacks from which she had suffered for some years, and which had lately become more frequent. She presented excessive mobility, occasional ecstatic phenomena, moderate attacks of hysteria, aphonia, irregular capricious appetite; in short, all the symptoms of hysteria with fair general health. She remained two months in the wards without having shown any other symptoms, when she was suddenly taken with epistaxis, diarrhœa, and weakness; the skin was hot and moist. She was supposed to have typhoid fever, although no rash could be found; and the diagnosis was doubtful. Her illness lasted forty days, and terminated fatally. At the necropsy there was found general peritonitis; the liver was enlarged and fatty; the pelvic peritoneum was covered with false membranes; the uterus was healthy and of normal size; the broad ligaments were thickened; the ovaries were healthy on section, surrounded by somewhat dense fibrous capsules. The Fallopian tubes were enlarged, and recognised with difficulty amidst the reddish-grey false membranes enveloping them; on section they appeared convoluted; their diameter was 6 millimètres, and their cavities were filled with caseous material. The lungs and other organs were healthy.

Robert Saundby, M.D.

4. *Dale on the Infection of Phthisis.* — Dr. W. Dale, in the *Lancet*, Dec. 1881, p. 1108, raises an earnest protest against the idea of infection in phthisis. A few cases that apparently lend support

to this view have been brought forward, but closer examination shows that they are not sufficient to affect the question in any way, seeing the immense amount of evidence on every side of us, proving that the disease is not infectious. Dr. Bale thus concludes his very valuable warning. 'I have only to add that I cannot imagine a more lamentable thing, than that the public at large should get the idea that phthisis is contagious, which appears to be held by some of the present race of practitioners, and held, I maintain, on the slightest and most insufficient grounds, without, as far as in one lies, earnestly protesting against it; for, seeing the disease is so widespread, and seizes young, delicate, and helpless girls and women chiefly, it seems to me that it were a barbarous and unwarrantable thing to raise the question of contagion in the public mind in connexion with it, and on evidence which I believe to be utterly worthless.' [Many papers for and against the contagious theory of phthisis are noticed in the *Med. Digest*, section 681-5; but the statistics of the Consumption Hospital, given by Dr. Cotton in the *Lancet*, vol. ii, 1867, p. 550, seem to place the fact of phthisis being non-contagious upon an immovable basis.—*Rep.*] Richard Neale, M.D.

5. *Mayor on Renal Lesions in Pregnant Women.*—Mayor (*Revue Méd. de la Suisse Rom.*) has classified the various renal alterations which may occur in pregnant women. Albuminuria of pregnancy is considered by some as due to purely mechanical causes, the uterus in its development compressing the arteries above the kidney, or the renal veins; according to other writers, albuminuria is the result of blood-changes; while others still regard it as a serumuria. From his own researches, Mayor is inclined to admit the constant existence of a nephritis, although he does not categorically assert it. 'All that we can affirm', he writes, 'is that on the one hand, in every case of eclampsia we have observed the existence of manifest lesions of the kidneys; and, on the other, the lesions of the secreting cellules of the kidney we have met with in pregnant women are those which Cornil has described as occurring at various periods in the course of parenchymatous nephritis. In puerperal nephritis, the first change is a period of congestion; this is followed by a period of inflammatory anæmia, during which the formation of casts and the dilatation of tubules take place. The lesions described are characteristic of nephritis, and do not pertain to the pathological process known as degeneration. This parenchymatous nephritis is allied to nephritis *à frigore*, and has no relation with the secondary nephritis of febrile affections and acute diseases, or with that form occurring in certain varieties of intoxication'. Chemical reaction of the albumen passed was thought to present another argument in favour of the similarity existing between puerperal nephritis and nephritis *à frigore*. Mayor cites a case which demonstrates that lesions of the kidney predispose women affected with uterine diseases to grave accidents, just as renal trouble exerts a baneful influence in traumatism. Albuminuria, however, may be absent during pregnancy, and may appear at the time of development of some febrile affection. We cannot look upon the nephritis of pregnancy as a constant precursor of puerperal phenomena and puerperal albuminuria. Nephritis of pregnancy, as well as the puerperal form, usually yields to treatment. During puerperal fever, changes in the kidney of various characters are met with; some of these changes begin during pregnancy, others belong properly to the puerperal state. The latter may occur under two different forms, either as parenchymatous changes, or as interstitial suppurative nephritis. The suppurative nephritis is probably similar to that observed in surgery, in pyæmia resulting from affection of one or the other part of the urinary tract (surgical kidney). The parenchymatous changes, in their elementary lesions, resemble those met with in parenchymatous nephritis *à frigore*, and is entitled to the name of puerperal nephritis. This form of parenchymatous nephritis gives rise to but one well-marked symptom—albuminuria. In its anatomical character and its clinical aspect, it differs from the renal changes of typhoid fever, and resembles nephritis *à frigore*.

6. *Sanders on Hæmorrhage into the Ventricles of the Brain.*—The symptomatology of primary, intermediate, or direct hæmorrhage into the cerebral ventricles, has been carefully investigated by Dr. Edward Sanders of New York, from an analysis of the clinical histories of ninety-four cases which he has diligently collated. The results of the study form an important contribution to the literature of this little known subject, and are published in the October (1881) issue of the *Amer. Jour. of the Med. Sciences*. The premonitory symptoms, as indeed those of onset, do not differ materially, where the effusion takes place primarily into the ventricles, from those of ordinary cerebral hæmorrhage. Cephalalgia is the most common and constant of the premonitory symptoms, and may have existed for a long time; dizziness is less frequently observed. The attack may be immediately fatal, or it may be ushered in by convulsions, by paralysis without loss of consciousness, by paralysis with partial or complete loss of consciousness, or by partial or complete loss of consciousness without paralysis: the latter being the most frequent mode of onset met with in primary intraventricular hæmorrhage, at least in this particular series of cases. The symptoms are elaborately considered. As regards the leading phenomena and their significance, it is stated that coma, whether light or profound, is to be considered 'as a constant symptom of primary intraventricular hæmorrhage'. As regards motor disturbances, no direct relation can be traced between the seat, amount, and extent of the ventricular extravasation and the presence or absence of muscular contractures; and the greatest variation is noticed in different cases in the amount, persistence, permanence, or tetanic characters of the spasm. Sanders says, in regard to general clonic convulsions, that he believes them to be 'one of the most important and frequent symptoms of immediate ventricular extravasation'. This may be attributable to direct injury from the effusion, or to its pressure upon adjacent motor centres. A careful comparison of simple and complicated cases, however, shows 'that the variety or extent of the complication has no essential bearing in the occurrence of convulsions, the ventricular extravasation itself being undoubtedly the inducing cause'. The *tâche cérébrale* may also be present. Where apparent improvement takes place, it is generally soon followed by symptoms of the most aggravated kind, terminating in death, no second remission having been observed in a single case.

7. *Key on Recurrent Retrobulbar Medullary Sarcoma: Metastasis in the Subdural Space of the Brain and Spinal Cord.*—Dr. Axel Key, who some years ago called attention to the conditions under

which metastasis of tumours occurred in the subarachnoid space of the brain and spinal cord, describes the following case in *Hygeia*, 1881 (*Nordiskt Med. Arkiv*, Band xiii, Häft 3). A lad, aged 16, showed, in the beginning of December, signs of a tumour in the right orbit, outside the eyeball. It grew so rapidly that, when he was admitted to hospital on January 3rd, it had displaced the eyeball, and pressed on the parietal sinus, the lachrymal passage, and the maxillary sinus. On the 10th, it was removed by Professor Rossander, but soon returned, and grew rapidly, until the boy's death on February 6th. It was then as large as a man's closed fist, had destroyed the bones of the face around the orbit as far as the palate, and had extended from the orbit to the dura mater, involving also a limited portion of the right anterior lobe of the brain, where there was firm adhesion between the dura mater and arachnoid and the surface of the brain. Beyond this, no formation of tumour was found anywhere in the subarachnoid space, or in the interior of the brain; and it was therefore evident that none of the diseased material had been carried into the subarachnoid space; at least, it had not there come into action. The growth was continuous in the dura mater as far as the foramen magnum, and extended 5 centimètres (nearly two inches) into the dura mater of the spinal cord, where it ended in a well-defined edge. Beyond this, there was no disease for about two inches; then it recommenced, not, however, being continuous, but appearing in the form of small nodular masses at the sides, along the lines of exit of the nerves and the attachments of the ligamentum denticulatum. Closer examination showed that it was not at the points of exit of the nerves, but around the processes of the denticulate ligament in connection with the dura mater, that the metastases had occurred. Dr. Key had not previously believed that these parts exclusively could be points at which the infective matter conveyed by the subdural space could be arrested, but he finds now that such is the case. The growth was a round-celled medullary sarcoma, with little or no intercellular substance. No metastatic deposits were found in any of the internal organs; and hence it was clear that there was no general infection, but that the growth had spread in a discontinuous manner, by metastasis, only within the subdural space.

A. Henry, M.D.

8. *Albert on a Case of Congenital Deficiency of Part of the Tibia.*—Deficiencies in the bones of the lower extremities are rare. Four cases have been recorded by Billroth, Pauly, and Albert, in one of which both legs were affected, in the other three the right tibia. In the case recorded by Professor Albert (*Allg. Wien. Med. Zeit.*, No. 27, 1881) the defect was also on the right side. The patient was a female infant four days old. The right foot was normal in form, but was so placed that the dorsum looked backward. On the inner side of the leg was a small navel-like tumour, under which the lower end of the tibia was to be felt. Only the upper two-thirds of the bone was present, and there seemed to have been a constriction of the leg at the point of defect. The movements of the foot were active.

9. *Baumgarten on the Transformation and Proliferation of the Epithelium of the Intestinal Lymphatics.*—Professor Baumgarten calls attention (*Centralbl. für die Med. Wissensch.*, No. 3, 1882) to the changes occurring in the epithelium of the intestinal lymphatics in inflammatory and other allied affections. The thin flattened cells swell out into large round or cubical cells, and frequently, by their proliferation, actually plug the widened lumen of the vessel, thus producing a histological tissue, allied in appearance to tubercular glands, or columns of cancer-cells, rather than to lymph-vessels. This result may be produced by inflammation, either of the serous or of the mucous coat, and it is best studied in the intralaminar lymphatic plexus of Auerbach, which lies between the two muscular layers. The inflammation need not by any means have extended by direct continuity to this tissue. The condition, which he calls lymphangitis hyperplastica intestinalis, is produced, he believes, by the absorption of inflammatory matter from a distance, just as lymphangitis is caused by inflammation of the skin. Dr. Baumgarten considers that his results give support to those who hold that certain forms of cancer may take origin from lymphatic epithelium; and, at the same time, they show the necessity for caution in reaching conclusions, as it appears that simple inflammatory irritation of lymph-vessels may produce the appearance of cancerous growths.

10. *Langhans on the Formation of Cavities in the Spinal Cord as a Result of Interruption to the Circulation.*—From the examination of four recent cases of this condition (syringomyelia), the writer comes to the conclusion (Virchow's *Archiv*, Band lxxxv, p. 1) that it results from abnormal pressure in the cerebellar vallecula. In all four cases there was a local compression; in the first three from sarcomatous tumours, in the last from some cause not related. Only the cervical part of the spinal cord was affected; and, in the first three, the cavity was distinctly made out to be a diverticulum from the central canal of the cord, having therewith only a very narrow communication, from which the cavity extended downwards, mostly in the anterior part of the posterior column. The condition results, according to this observer, from the deposition of gelatinous material between the nervous elements; a special form of œdema, analogous to internal hydrocephalus from pressure on the venæ Galeni.

11. *Rosenberger on the Nature of the Septic Poison.*—Dr. Rosenberger puts the question (*Centralbl. fur die Med. Wiss.*, No. 4, 1882), Can an animal be infected by means of minute quantities of the serum or blood of another which has died from the effects of a boiled septic poison? An animal killed by a septic poison which has been boiled and is thus free from bacteria, cannot be said to have been infected; it has been poisoned, and if there be in its body no multiplication of the poison, small quantities of its serum or blood ought no more to be capable of poisoning another than the same amounts taken from an animal poisoned with strychnia. To answer the question, Dr. Rosenberger boiled and filtered considerable quantities of septic blood and other fluids. The invariable result of an injection of the fluid thus obtained was death, with the *post mortem* appearances of septicæmia, and the presence in the animal fluids of the same micro-organisms, and in the same amount as in the animals killed by the unboiled poison; with this difference, however, that the boiling evidently much diminished the virulence of the septic poison, as much as 1 cubic centimètre being necessary to kill a rabbit; while, of the unboiled poison, the amount held on the point of a needle was sufficient. Experiments made with the blood, etc., of animals so killed by the boiled septic fluid, brought out the fact that the smallest quan-

tities were sufficient to cause death. That is, the poison had again reached its former virulence. To make absolutely certain that no organisms were contained in the boiled septic fluid, it was allowed to remain two hours in the vessel at a temperature of about 140 deg. Cent. (284 deg. Fahr.), and a perfectly new syringe was used, after previous disinfection with carbolic acid and absolute alcohol. Control experiments of the most careful kind were also made. Dr. Rosenberger recognises two kinds of septicæmia in rabbits—that known as Pasteur's (the malignant œdema of Koch), and that known as Davaine's, both alike in the clinical features and the grosser pathological appearances, but differing in the species of bacteria present, of which a full description is given. He found that the micro-organism resulting from the injection of the boiled septic fluid of these varieties of septicæmia was invariably that peculiar to the form from which it was derived. Control experiments with these fluids were also made by means of cultivation. From these experiments, Dr. Rosenberger considers himself justified in drawing the following conclusions. 1. In septic infection, the bacteria are not primary but secondary, always receiving their virulence from meeting with a chemical or unformed poison. 2. The bacteria, and these alone, multiply the septic poison in living animals; and the origin of these specific bacteria of septicæmia is, he believes, the schizomycetæ naturally present in the body, and modified through the action of the septic poison present in the boiled fluids.

12. *Nauwerk on the Pathology of the Brain.*—Dr. Nauwerk makes the following contributions to the pathology of the brain, in *Deutsches Archiv für Klin. Med.*, Band xxix, p. 1. 1. *Purulent Meningitis in Croupous Pneumonia.*—Of 1,172 cases of croupous pneumonia treated in the Zürich Hospital from 1869 to 1879, 14 were complicated with purulent meningitis; all fourteen died. As there were no cases of epidemic cerebro-spinal meningitis, a special cause for the complication had to be sought. The patients were mostly drunkards or aged individuals. There was purulent infiltration of the lungs; and the writer believes the cause of the meningitis in such cases to be embolism of the cerebral arteries, either from vegetations in the heart and ulcerative endocarditis, or from thrombi in the lungs. 2. *Cerebral Abscess.*—A male, aged 35, had, at the age of seven years, received a severe blow on the head from an axe, fracturing the right parietal bone and injuring the brain. He did not lose consciousness, and was able to walk home, feeling, however, slight weakness of the left limbs, which persisted throughout life. For three years after the injury, there occurred every three or four weeks convulsive attacks confined to the right arm and leg, and accompanied by no loss of consciousness. For the next twenty-three years he felt quite well; but, in the beginning of 1879, the convulsions of the left limbs again returned, the muscles of the face and neck being now occasionally involved, but the consciousness still perfectly clear. He had headache, exaggerated left tendon reflex, slight left anæsthesia, and neuroretinitis. The facial nerve was unaffected. In the first half of 1880 there were almost daily convulsive seizures, frequently, also, vomiting. On June 17th, 1880, death occurred. The *post mortem* examination showed multiple cortical abscesses in the right hemisphere, and defect of the cortex in the right fissure of Rolando. JAMES ANDERSON, M.D.

OBSTETRICS AND GYNÆCOLOGY.

RECENT PAPERS.

1. AHLFELD, F.—On the Morbidity in Lying-in Hospitals. (*Centralbl. fur Gynak*, den 14 Jan. 1882.)

2. AUVARD.—Modification of Cusco's Speculum. (*Annales de Gynéc.*, Jan. 1882.)

3. BANTI, GUIDO.—Anatomico-Pathological Study of General Hypertrophy of the Mammæ. (*Arch. della Scuola d'Anat. Patol. di Firenze.* Volume Secondo.)

4. BUDIN, P.—The Diagnosis of Pelvic Presentation during Pregnancy. (*Annales de Gynéc*, Jan. 1882.)

5. FRANK.—Contribution to the Study of Cæsarean Section. (*Centralbl. für Gynäk.*, den 10 Dec. 1881.)

6. GALLARD, T.—Primary Cancer of the Uterine Mucosa. (*Jour. de Méd. de Paris*, 14 Jan. 1882.)

7. GARRIGUES, H. J.—A New Form of Vaginal Depressor. (*New York Med. Record.*)

8. GRENSER.—On Labour in Old Primiparæ in Private Practice. (Leipzig: W. Engelmann, 1881.)

9. HOFMEIER.—On the Etiology of Rupture of the Uterus. (*Centralbl. fur Gynak.*, den 24 Dec. 1881.)

10. KUSTNER, O.—On the Pathology and Therapeutics of Vulvar Carcinoma. (*Zeitsch. fur Geburtshülfe und Gynak.*, Band vii, Heft 1.)

11. MARSH, J. O.—Menorrhagia and Metrorrhagia of the Climacteric Period. (*Obst. Gaz.*, Cincinnati, Dec. 1881.)

12. MARTIN, A.—Hæmatometra following Typhus Fever. (*Centralbl. fur Gynäk.*, den 24 Dec. 1881.)

13. MONOD, CH.—Enormous Distension of the Breasts in a Pregnant Woman. (*Soc. de Chir.*, Paris, 10 Aout, 1881.)

14. MORISANI.—On Symphyseotomy. (*Annales de Gynéc.*, Dec. 1881.)

15. PAJOT.—Difficult Labour from Abnormal Direction of the Expulsive Powers. (*Ibid.*, Jan. 1882.)

16. PARTRIDGE, E. L.—Accidental *ante partum* Hæmorrhage. (*New York Med. Jour. and Obst. Reviewer.*)

17. PROKOWNIK.—Pruritus Uterinus. (*Centralbl. für Gynäk.*, den 10 Dec. 1881.)

18. PUCCI, PIETRO.—Dystocia from Two Fœtuses United by a Membranous Canal. (*Rivista Clinica di Bologna*, Ottobre 1881.)

19. SHALLER, J. M.—Adherent Placenta. (*Obst. Gaz.*, Cincinnati, Nov. 1881.)

3. *Banti on Hypertrophy of the Mammæ.*—Dr. Banti is of opinion that the condition called hypertrophy of the mammæ exists in two forms. The first variety is that of false hypertrophy, which itself may be divided into three different varieties. The second form is a hyperplasia of all the tissues which compose the mamma, glandular as well as connective. This is true hypertrophy. He regards true and false hypertrophy as being two distinct entities, and cannot regard them, as some authors do, as merely two stages of the same disease.

4. *Budin on Presentation of the Pelvic Extremity during the Last Weeks of Pregnancy.*—Dr. Budin gives details of six cases, in which the pelvic extremity of the fœtus presented, and became permanently engaged in the upper strait of the pelvis during the last week or two of pregnancy. In general, the fœtuses were rather small, the liquor amnii was scanty, and the uterus was firmly contracted upon the fœtus. Most authors omit to mention the fact that the breech may engage in the pelvis before labour and pass through first. Other authors deny the possibility of such a thing happening.

12. *Martin on Hæmatometra after Typhus.*—Fran. G., aged 28, menstruated at 15; had three normal labours; the last two years before the present attack. In

September 1880 she had a severe attack of typhus fever, during which there was a profuse discharge from the genital organs. At the beginning of October 1880, whilst the patient was unconscious, a fetid cylindrical mass was evacuated *per vaginam*, which was recognised as the cervix uteri with the upper portion of the vaginal canal. The patient recovered from the typhus fever with aphonia, but there was no complaint of any uterine trouble. The menses did not reappear, and their normal dates were marked in November, December, and January, by severe abdominal pain, but by no escape of any discharge. On January 31, 1881, the following condition was found on examination; abdomen tender; vagina tolerably broad, very short; just about halfway up the normal vaginal distance, the finger detected a transverse cicatrix, on which several warty projections could be felt. On bimanual examination, a large tumour, of the size of two fists, could be felt filling the vagina. On February 2, 1881, the cicatrix was stretched and divided, and the sound passed through into the uterus. Characteristic decomposed hæmatometric blood then escaped. The cicatrix was then further incised on each side of the sound, and dilated with the finger, so that a good opening was made into the uterine sac. A drainage-tube, surrounded with a pad of cotton-wool, was now inserted. During the following days, a large quantity of dark blood escaped. The uterus slowly contracted to the size of a fist. There was no febrile complication; the pulse and temperature remained normal. By the time the patient got up, the uterus had still further contracted. The wound had contracted closely round the drainage-tube, and had become covered with skin. The menses appeared, without pain, three weeks after the operation. On May 15, the drainage-tube was removed, whereupon the cicatrix contracted to such an extent that a secondary operation became necessary. The whole cicatrix was excised, and the vagina united by deep sutures with the body of the uterus. This procedure left a free open canal for the menstrual discharge. On examination, on November 22, the short vagina was found to terminate in a transverse slit, with anterior and posterior lips. The sound passed in through this opening to a distance of 6.5 centimètres. The uterine body appeared to be of the normal thickness. Dr. Martin states that such atresiæ after typhus are not common.

13. *Monod on Enormous Distension of the Breasts during Pregnancy.*—The patient, shown to the Société de Chirurgie by M. Monod, was pregnant four months; the breasts had acquired an enormous development. She had already had two pregnancies, and during each the breasts had become very voluminous. In the second pregnancy, the milk flowed in such abundance that she was, so to speak, drowned by it. When shown, she was four months pregnant, the swelling had existed two months, and the emaciation of the patient was marked. M. Monod asked what was to be done. Ablation of the breasts could not be thought of; it would be dangerous during pregnancy, and palliatives were insufficient. He thought the case should be placed in the category of contracted pelves, and abortion induced. M. Després said the case was exceptional; nothing similar had been published. He thought suction would be useful. M. Horteloup would wait until the exhaustion increased before producing abortion. M. Sée was of opinion that suction would only augment the weakness of the patient, just as tapping in ascites, by causing fresh secretion of fluid, reduced the strength of the patient. He agreed with M. Monod, that abortion should be produced. M. Monod said three similar cases had been published in a thesis by Labarraque, and in these cases the hypertrophy had disappeared with the termination of the pregnancy. Hence he thought abortion would be the only effectual means of reducing the hypertrophy.

14. *Morisani on Symphyseotomy.*—Dr. Morisani gives statistics of 50 cases, in which symphyseotomy has been performed at Naples on 48 women. In two cases, the operation was performed twice on the same subject. Of these, 40 mothers survived, 10 died; 41 children survived, 9 died. Sometimes the operation had been performed some time after the beginning of labour, and in several cases the child had been treated to other different manœuvres and operations before the operation of dividing the symphysis pubis was resorted to. The diameters of the pelvis varied. In 12 cases, the conjugate was 81 millimètres; in 16 it was 74 millimètres; in 7, it was 69 millimètres; in 13, it was 67 millimètres; and in 2 cases it measured only 61 millimètres; but these were exceptional cases. The operation thus ranged between 81 millimètres and 67 millimètres. The only operation, in the opinion of Dr. Morisani, which competes with symphyseotomy, is embryotomy. Tibone lost 21 mothers out of 100 after embryotomy. Chiara lost 24 mothers in 100 such cases. He compares these figures with 10 deaths out of 50 cases of symphyseotomy, and remarks that the mortality among the mothers is less, and that, whilst by embryotomy all the children were destroyed, 41 out of 50 fœtal lives were saved by the division of the symphysis. The method resorted to by Morisani, in performing symphyseotomy, is as follows. A small, crotchet-shaped, blunt-pointed knife, curved, and cutting on its concave edge, is used. It is known as the *falcetta di Galbiati*. An incision of from 3 to 5 centimètres is made just above the symphysis pubis. The articulation is gradually reached, the *falcetta* is slipped along the posterior surface of the symphysis, and, once the lower edge of the symphysis is reached, the cutting concavity of the instrument is hooked under the interpubic cartilage, which is then cut through from below upwards. If the uterine contractions are strong, the expulsion of the child is then allowed to take place spontaneously. If they are feeble, or the head does not descend, the forceps is applied. Lastly, the wound is dressed, and immobility of the pelvis secured by an appropriate bandage. The operation of symphyseotomy has been performed in the obstetric clinic, and maternity ward of the hospital for incurables at Naples. The period traversed is from 1868 to the end of December 1880. The chief operators were Novi, Martini, and Morisani.

18. *Pucci on Dystocia from Joined Fœtuses.*—The fœtuses were united by integument between the abdomens. The uniting canal was divided by scissors. The liver, intestines, and umbilical cord were implicated. The section made, the first fœtus was delivered by the forceps and the second by turning. The twins were male, fully developed at term. The second presented no umbilicus; in the first the umbilicus was situated in its usual position. The funis was inserted into a single placenta of normal size. It contained two arteries and one vein. The uniting integument was composed of a canal three fingers' breadth in length, with walls of the same structure and thickness as the abdominal skin. The canal formed a means of communication between the two

abdominal cavities. It was symmetrically inserted at its two extremities into each fœtus, near the centre of the epigastric region.

Fancourt Barnes, M.D.

DISEASES OF THE THROAT.

RECENT PAPERS.

1. Fauvel.—A Bullet that had lodged in the Head found Ten Years afterwards in the Larynx. (*Rev. Mens. de Laryngol.*, Oct. 1881.)

2. Ehrendorfer.—Enchondroma of the Larynx. (*Wiener Med. Woch.*, (July 2, 1881.)

3. Coupard.—Paralysis of the Left Inferior Vocal Cord, produced by Glandular Compression. (*Revue Mens. de Laryngol.*, Dec. 1881.)

4. Morrill.—Spasms of the Glottis in a Child. (*Boston Med. and Surg. Jour.*, Feb. 19, 1881.)

5. Potain.—Spasms of the Glottis, and Ovarian Congestion. (*Revue Mens. de Laryngol.*, Nov. 1881.)

6. Boyer.—The Influence of the Sexual Apparatus of the Female upon the Vocal Organs and upon the Formation of the Voice. (*Ibid.*)

7. Whitehead.—Excision of the Thyroid Gland. (*Brit. Med. Jour.*, Nov. 12, 1881.)

8. Richelot.—A case of Thyroidectomy. (*Gaz. Hebd. de Med. et de Chir.*, Nov. 25, 1881.)

9. Krishaber.—(Esophageal Tubes. (*Ann. des Mal. du Larynx*, etc., Dec. 1881.)

10. Fruhwald.—Polypus on the Right Tonsil. (*Revue Mens. de Laryngol.*, Nov. 1881.)

11. Armanqué.—The Treatment of Inflammation and Hypertrophy of the Tonsils by Bicarbonate of Soda. (*El Siglo Med.: Revue Mens. de Laryngol.*, Nov. 1881.)

12. Plexiform Sarcoma in the Upper Part of the Pharynx. (*Wiener Med. Woch.*, July 2, 1881.)

13. Cozzolino.—Ozæna and its Clinical Forms. (*Revue Mens. de Laryngol.*, Nov. 1881.)

14. Smith, J. L.—Treatment of Laryngitis in Infants. (*Louisville Med. News.*)

15. Martin.—Special Points in Operating for Tracheotomy in Croup. (*Annals of Anat. and Surg.*)

1. *Fauvel on a Bullet that had lodged in the Head found Ten Years afterwards in the Larynx.*—Dr. Fauvel contributes the following curious case (*Revue Mens. de Laryngol.*, Oct. 1881.) The patient, ten years before, had received a gun-shot wound under the left eye; and medical opinion was divided as to whether the bullet had remained in the head or not. For three months, pus and small pieces of bone were discharged through the mouth. The man had since suffered, at frequent intervals, from acute pain in the head and jaws, and his general health was impaired. Seven months ago, he first felt pain in the throat, and in the jaw near the temporo-maxillary articulation and left ear, with pricking sensations, which he compared to a needle plunged in the ear. Later on, the same pricking sensation and pain were felt in the left side of the larynx. There were expectoration of blood, cough, hoarseness, trouble in swallowing, and finally aphonia. Liquids could scarcely pass. At this crisis laryngoscopic examination was made, and a dark, irregular, lobulated, fungating-looking mass was discovered, filling up the left half of the glottis and concealing the greater part of the left vocal cord. The other parts of the throat were normal. The tumour most resembled a melanotic growth; but, in consideration of the rarity of such growths in this situation, it was thought rather that the patient was suffering from the ulcerative stage of laryngeal phthisis. But afterwards, as the tumour increased in size, and seemed very firm and resisting to the touch, it was diagnosed as osteoma, and its extraction decided on. Attempts that were made to remove it were not at first successful. The patient passed the night in coughing and vomiting; and, during a fit more violent than the rest, expelled a heavy, hard body, which proved to be a bullet. From this date the patient recovered his voice, and all pain and trouble in swallowing disappeared. Nothing could be seen of the tumour, except the slight scar where the bullet had passed through. On rhinoscopic examination, some small perforations in the upper part of the naso-pharynx were discovered. Dr. Fauvel, after remarking upon the difficulty attaching to the diagnosis of this case, says that it is equally difficult to explain the manner in which the ball passed downwards into the larynx. He suggests that, having entered apparently below the malar bone, the bullet penetrated obliquely between the ascending ramus of the inferior maxillary and the superior maxillary bone, and became lodged in the basilar process of the occipital bone, in front of the vertebral column, and behind the pharyngeal aponeurosis. The ball, instead of becoming encysted, was probably set free by the surrounding bone becoming necrosed, which would account for the discharge of the pus and spicula of bone, and the perforations in the naso-pharynx afterwards seen by the rhinoscope. Yielding to the force of gravity, it then slowly descended in front and to the left of the vertebral column, being concealed from view, first, by the veil of the palate, and afterwards by the posterior pillars of the fauces. When it reached the base of the tongue, it changed its direction, and, passing forwards and downwards, became lodged in the left ary-epiglottidean fold.

2. *Ehrendorfer on Enchondroma of the Larynx.*—The author records (*Wien. Med. Woch.*, July 2, 1881) a case of this extremely rare affection. The patient was a woman aged 73, who had suffered from paralysis of the left vocal cord for three years, not relieved by electricity. A year later, a small tumour, growing from the back of the larynx near the left vocal cord, was discovered. It increased in size, ulcerated, and was diagnosed as carcinomatous. Two years after its first appearance, swallowing and respiration became difficult, and tracheotomy was resorted to. During the insertion of the cannula, a portion of the growth was accidentally removed, and was seen to be of a cartilaginous nature. Three weeks afterwards, Professor Billroth extracted the tumour by making an incision over the left side of the neck, and separating the tumour with the fingers from its connections. It grew from the back of the cricoid cartilage, whence it had made its way into the larynx by passing between the two arytenoid cartilages. Cicatrisation of the wound was retarded by the escape of food. The existence of granulations in the larynx necessitated the introduction of special conical sounds for some time after the external wound had cicatrised. The tumour was four centimètres long, three wide, and two in thickness. It was composed of hyaline cartilage, intermixed with connective tissue. A few small cysts were also scattered through its substance.

3. *Coupard on Paralysis of the Left Inferior Vocal Cord, produced by Glandular Compression.*—The voice of the patient (*Revue Mens. de Laryngol.*, Dec. 1881) varied with the position of the head. If the head were held straight, the voice was hoarse; if turned to the right, it was somewhat stronger in tone; if to the left, there was complete aphonia.

The health was generally impaired. Laryngoscopic examination revealed immobility of the left arytenoid cartilage, and relaxation and outward deflection of the left vocal cord. On external examination, a tumour, of the size of a large almond, hard, non-adherent, and evidently an enlarged gland, was found under the left sterno-cleido-mastoid muscle, near the cricoid cartilage. As there was a doubtful history of syphilis, the treatment consisted of internal and external applications of iodide of potassium. A month afterwards, the gland had decreased notably, and the health and voice were much improved. When seen more than a year afterwards, the patient was in good health; the gland had not entirely disappeared, but the weakness in the voice was only apparent when the head was forcibly inclined to the left. [Notes of a similar case are published in the *Archives of Laryngol.*, No. 1, 1880 (London Medical Record, June 15, 1880). In that case there was incomplete abduction and relaxation of the right vocal cord, and an enlarged gland was found in the neck on the right side of the trachea, just below the level of the cricoid cartilage, projecting into the groove between it and the œsophagus. Another case is related in the *Alienist and Neurologist*, No. 2, 1880. Here the injection of acetic acid into the gland produced its reduction. In the London Medical Record, for Dec. 1881, p. 518, is an abstract of a paper by Dr. Gouguenheim, in which he describes, as one cause of paralysis of the cords, the enlargement of some small glands situated in the space between the larynx, trachea, and œsophagus. These glands are not always present, or are so small that their presence is easily overlooked; and they are, consequently, not described in anatomical works.—*Rep.*]

4. *Morrill on Spasms of the Larynx in a Child.*—A child nine months old (*Boston Med. and Surg. Jour.*, Feb. 19, 1881; *Paris Méd.*, Nov. 12, 1881), of scrofulous temperament, had been suffering from catarrhal laryngitis for two days, when he was suddenly seized with spasms of the larynx, threatening suffocation. Dr. Morrill, who was hastily summoned, observed that there was glandular enlargement on each side of the neck, without, however, any visible fluctuation. He incised the enlargement on the left side; and blood and pus were let out, to the relief of the symptoms. The same operation was performed on the other side of the neck two days later. Dr. Morrill considers that here the spasms were the result of direct compression of the larynx, and, at the same time, of the recurrent laryngeal nerve.

5. *Potain on Spasms of the Glottis, and Ovarian Congestion.*—The patient, a young girl (*Revue Mens. de Laryngol.*, Nov. 1881), suffered from difficult and noisy respiration. The laryngeal respiration was difficult, but the voice was clear. There was, however, no cough, pain, or physical signs on examination with the laryngoscope. The menstrual functions had been disturbed. The right ovary was found increased in sensibility. There was marked hyperæsthesia of the whole of the right side and analgesia of the upper extremity, resulting from some ovarian disturbance. Dr. Potain attributes the spasms of the glottis to the same cause.

7. *Whitehead on Excision of the Thyroid Gland.*—Mr. Whitehead reports a case (*Brit. Med. Jour.*, Nov. 12, 1881) of excision of the thyroid gland in an unmarried woman, aged 57. The growth had existed thirty years, but within the last five years had increased rapidly, to the great inconvenience of the patient, who suffered from hoarseness, difficult respiration, and occasional paroxysms of dyspnœa. The tumour occupied the front of the neck, the upper border being on a level with the thyroid cartilage. It hung down in a pendulous manner on to the upper border of the sternum, and the base of its attachment extended laterally to the borders of the sterno-mastoid muscle, which were displaced by the growth. The tumour was lobulated, some of the lobes conveying a sense of fluctuation, whilst others appeared solid. The mobility of the tumour, the probability of its being of a 'fibro-cystic' nature, together with the fact that it was increasing steadily in size, and the impossibility of forming an opinion as to the ultimate size it might attain, appeared to suggest and warrant an attempt at extirpation. A vertical median incision, four inches long, was made from the upper border of the thyroid cartilage to the sternum; the sterno-hyoid and thyroid muscles were drawn aside; the superior and inferior thyroid arteries were secured, and the capsule was divided. The lateral lobes were freed by careful dissection, and the whole gland was removed by enucleation. The operation was performed antiseptically, and the patient made a complete recovery. The day after the operation there was complete aphonia; but the voice subsequently improved. The tumour was found to consist of several cysts, with interposing masses of solid tissue. The lateral lobes were hypertrophied and calcareous. Pedunculated growths descended from the central mass. [The microscopic structure of the tumour is not given.—*Rep.*]

8. *Richelot on a case of Thyroidectomy.*—This case is reported in the *Gaz. Hebdom. de Méd. et de Chir.*, Nov. 25, 1881. The patient, aged 25, was the subject of a large goitre. Six years previously, it had been punctured, and iodine injected. It had slightly improved; and four years later, three capillary punctures were made. When the patient entered the hospital, she was suffering from intense dyspnœa and dysphagia. The goitre was of the size of a child's fist, without any apparent prolongation towards the sternum. A curved incision, with its convexity downwards, was made. The loss of blood was almost as great as that usually following amputation of a limb. The operation, with the dressing, lasted two hours. Immediately after the operation, there was complete aphonia. The laryngoscope showed immobility of the vocal cords. Dr. Krishaber concluded that both the recurrent nerves had been cut. Four months afterwards, however, the voice reappeared with its normal tones.

9. *Krishaber on the Œsophageal Tube.*—The conclusions of M. Krishaber on this subject (*Ann. des Mal. du Larynx, etc.*, Dec. 1881) are as follows. 1. The œsophagus can bear the retention of a tube *in situ* for an indefinite time. 2. The tube must be introduced by one of the nostrils, and not by the mouth. 3. The continual presence of the tube produces the degree of dilatation necessary for the insertion of increasingly larger tubes, as is the case in catheterisation of the urethra. 4. In cases where the stenosis is too great to permit the introduction of a soft tube, a gum catheter should be first introduced, and replaced, after several days, by one made of caoutchouc, which is softer and more easily tolerated. The substitution of the second tube should be made immediately after the withdrawal of the first. 5. Alimentation is assured, and false passages, that are apt to be made by intermittent catheterisations, are avoided. 6. In cases where the stenosis requires œsophagotomy, the tube should be placed *in situ* immediately the incision is made, so that cicatrisation goes on around the tube, and coarctation of

the œsophagus is avoided. 7. The tube may also be employed in the same manner to nourish phthisical patients, paralytics, lunatics, or patients in a state of coma or stupor. 8. The tube is of incontestable utility for large operations on the face, mouth, or naso-pharyngeal cavity. In these latter cases, the soft caoutchouc tube should be placed in the œsophagus several days before the operation, and should remain in until the complete recovery of the patient. [At a recent discussion on œsophagotomy, at the Clinical Society, Mr. Durham stated that he had treated several cases of stricture of the œsophagus by the retention of œsophageal tubes *in situ* with marked success. In his cases, however, the tubes were all introduced through the mouth, and not through the nose, as recommended by Krishaber. Mr. Durham's patients experienced no inconvenience from the presence of the tube, which was secured to one corner of the mouth.—*Rep.*]

10. *Fruhwald on Polypus on the Right Tonsil.*—The patient (*Wiener Med. Woch.*, No. 44, 1879; *Revue de Laryngol.*, Nov. 1881) was a man aged 40. The right tonsil was hypertrophied, and attached to it was a large polypus, of the size of an almond, the pedicle being six millimètres long. In certain positions it threatened suffocation. It was removed with the scissors. The microscopical structure was that of an hypertrophied tonsil.

11. *Armanqué on the Treatment of Inflammation and Hypertrophy of the Tonsils by Bicarbonate of Soda.*—Dr. Armanqué records (*El Siglo Med.; Revue Mens. de Laryngol.*, Nov. 1881) seven cases of acute tonsillitis, cured in twenty-four hours, by the application of bicarbonate of soda. This treatment was first recommended by Dr. Giné, who used bicarbonate of soda either by insufflation, or by direct application made by the finger of the patient. Dr. Giné reckoned the cases by dozens where cure resulted in twenty-four hours; in no case did the treatment remain without effect. Relief is nearly always immediate. The efficacy of this treatment is most marked in the early stages. Bicarbonate of soda does not lessen the predisposition to sore-throats, but arrests its development. With the frequent application of bicarbonate of soda, hypertrophy of the tonsils is also overcome in a short time, thus rendering excision of the tonsils unnecessary. The cases quoted by Dr. Armanqué confirm the opinion of Dr. Giné concerning the efficacy and rapidity of action of bicarbonate of soda.

12. *Plexiform Sarcoma in the Upper Part of the Pharynx.*—This case is recorded in the *Wiener Med. Woch.*, July 2, 1881 (*Revue Men. de Laryngol.*, Dec. 1881). For two years the patient, a woman aged 48, had complained of increasing trouble in deglutition. With the laryngoscope, a small white swelling was seen partly hiding the laryngeal aperture. The tumour could be felt on external pressure, and the submaxillary glands were enlarged. After having made fruitless efforts to extract the tumour by the mouth, Professor Billroth performed pharyngotomy, opening the pharynx and upper part of the œsophagus. The tumour grew from the posterior part of the pharynx by a pedicle of about the thickness of a quill. It was excised and the wound sutured, the operator taking care to remove all the enlarged glands before closing the wound. Union took place by the first intention. The tumour, which measured 4 centimètres in length, 2 in width, and 1½ in thickness, was composed, in great part, of cylindrical epithelium in process of development. On section, the capillary vessels contained in it showed the epithelium in process of proliferation.

13. *Cozzolino on Ozæna and its Clinical Forms.*—Dr. Cozzolino has just published, under the above title (Naples, 1881; *Revue Mens. de Laryngol.*, Nov. 1, 1881), a work in which he considers all the present views of ozæna. He recognises three forms. 1. Constitutional ozæna, or scrofulous rhinitis; 2. Catarrhal ozæna due to an atrophy of the mucous membrane; and 3. Simple ozæna. He considers the first variety, not as a local malady, but as a localisation of the scrofulous diathesis in the nasal mucous membrane. In this variety, the products of the secretions take the form of greenish crusts. Syphilitic rhinitis may be sometimes met with allied to the scrofulous form. The fœtor may be due, 1, to the diminution of the nasal fossæ by malformation or stenosis, the result of tumours, hypertrophies, etc.; 2. to the augmentation of the nasal cavity by atrophy or absence of the inferior spongy bones; 3. to a catarrhal inflammation favouring the decomposition of pus, or to graver morbid alteration (ulceration, caries, necrosis); to malignant tumours; or, finally to a simple decomposition of the secretion, as is observed in caseous coryza, in scrofulous ozæna, and in simple ozæna. The second form, atrophic rhinitis, is usually an affection of youth, and is the result of chronic rhinitis, and never occurs but in scrofulous subjects. Prognosis is much more favourable than in the preceding form, especially if the morbid process has not arrived at the atrophic stage. Under the third form, simple ozæna, the author discusses the theory of Hebdemus of Dresden, who believes that the fœtor is the result of a gaseous exhalation from a mucous membrane deprived of secretion: and the view of Fraenkel, who denies that ozæna can exist without increased secretion. Dr. Cozzolino, for his own part, believes that simple ozæna may exist in certain individuals who have naturally fetid secretions, as of the feet, axilla, etc. The treatment in this case can only be palliative. Each form of the affection will require both local and general treatment. As the indications for local treatment, the author enumerates the following: 1. To modify the surface of the mucous membrane; 2. To modify the consistency of the secretions; 3. To arrest local inflammation; 4. To modify locally the secretory products; 5. To repress or destroy exuberant tissues.

W. J. Walsham, M.B.

14. *Smith on the Treatment of Laryngitis in Infants.*—Dr. J. Lewis Smith says (*Louisville Med. News*) that in ordinary cases the yellow sulphate of mercury, prescribed in powder in two-grain doses, may be administered as an emetic. The atmosphere which the child breathes should be constantly loaded with moisture, without, however, that degree of heat which would add to the discomfort of the patient. Moist air promotes expectoration and renders the cough looser. A temperature of 75 deg. to 80 deg. Fahr. is required. The following will be found a most efficient solvent for the pseudo-membrane, and should be used in the steam-atomiser:—R Calcis, ℥ ss; aquæ, fl. ℥ viij; glycerinæ, ℥ij; mix. Each second hour one ounce of the following should be used, the lime-water being used constantly between times:—R. Potassæ chloratis, ʒij; ammonii chloridi, ʒj; glycerinæ, ℥ij; aquæ, ℥vi. The inhalation may be continued for two hours without wearying the child. If the temperature be high, quinine should be given in two or three large doses. As regards local measures, cold water may be constantly dropped from a sponge upon a compress laid over the throat of the child, or

two or three thicknesses of muslin soaked with camphorated oil may be applied over the larynx so as to cover the neck in front, and over this a bladder containing pieces of ice, or ice surrounded by oil-silk, to prevent dripping. If oxygen be obtainable, the inhalation of this agent will be found to relieve the dyspnœa.

15. *Martin on Special Points in Operating for Tracheotomy in Croup.*—Dr. William M. Martin (*Annals of Anatomy and Surgery*) gives the following. 1. That procedure is the best which dispenses with the cannula or any mechanical appliance whatever placed within the trachea, and hence the excision method, or separating the wound by wires or threads passed through the lips of the divided trachea, is to be preferred, and appears to be based upon the soundest surgical principles. 2. Tracheotomy proper is to be selected in all exudative inflammations of the windpipe. 3. The low operation is preferable on account of the greater diameter of the trachea at its middle in children, the upper portion of that tube near and at its juncture with the larynx being more contracted in early life; and, again, the further down the opening, the more apt it is to be lower than the obstructive exudate. 4. The recumbent position of the patient, with the neck raised and somewhat extended, offers the easiest posture for operation. 5. An anæsthetic is most desirable, and preference should be given to chloroform on account of its less irritating properties. It is readily administered, and but a small quantity is required to produce unconsciousness, which state should be just reached; for if reflex action be wholly abolished, the surgeon loses the valuable aid of cough in notifying him of blood passing into the trachea, and in expelling it therefrom. In a word, reduction of the cutaneous sensibility is all that is required.

DERMATOLOGY.

RECENT PAPERS.

1. Neisser. — On the Use of Naphthol in Skin-Diseases. (*Centralbl. für die Med. Wiss.*, No. 30, 1881.)

2. Unna.—On the Treatment of Cicatrices. (*Mittheil. des Schleswigholst. Vereins der Ærzte*, 1881. Abstracted in *Vierteljahr. für Derm. und Syph.* Heft 2 and 3, 1881, p. 499.)

3. Lassar, Lewin, and Köbner.—Discussion on the Treatment of Eczema. (*Berl. Klin. Woch.*, No. 2 and 3, 1882.)

4. Kohn, S.—On Trichorrhexis Nodosa. (*Viertelj. fur Derm. und Syph.*, Heft 4, 1881.)

5. Hebra.—On Rhinophyma. (*Ibid.*)

6. Damon, Howard F.—Pemphigus Acutus seu Febrilis. (*Arch. of Derm.*, No. 3, 1881.)

7. Bulkley, L. Duncan.—On the Use of Mineral Waters in the Treatment of Eczema. (*Ibid.*)

8. Pellizzari, Celso.—Certain Eruptions of the Skin produced by the Pathogenic Action of Iodide of Potassium. (*Ibid.*)

9. Stelwagon, H. W.—A Case of Phthiriasis Palpebrarum. (*Ibid.*)

10. Hebra, Hans.—A Case of Symmetrical Partial Congenital Defect of the Cutis. (*Arch. of Derm*, No. 4, 1881.)

11. Bulkley, L. Duncan.—A Second Case of Lichen Planus affecting the Penis before developing elsewhere. (*Ibid.*)

12. Robinson.—The Anatomical Seat of the Parasite in Tinea Tonsurans Capillitii. (*New York Med. Jour.*, 1881, vol. 33, p. 289.)

13. Goldsmith.—Pigeon-Lice infesting the Skin of a Woman. (*New York Med. Record.*)

14. Besnier, Ernest.—On a Tumour of the Skin, which was Clinically a Cancer, but Histologically doubtful in its Nature. (*Annales de Derm. et de Syph.*, 2me Série, vol. 2, No. 4.)

15. Cornil and Suchard.—Note on the Seat of the Parasites of Leprosy. (*Ibid.*)

16. Brachet and Monnard.—A Case of Xanthoma forming Tumours. (*Ibid.*)

17. Barthélemy. — A Case of Scleroderma in Patches. (*Ibid.*)

18. Hardy.—Note on Pellagra. (Discussion in the French Academy of Medicine, 28 June and 5 July, 1881. *Ibid.*, p. 719.)

19. Déjerine.—Changes in the Cutaneous Nerves in Pellagra. (*Ibid.*, p. 719, and *Gaz. Hebd.*, Nos. 26, 27, and 29.)

20. Pospelow.—Lichen Ruber Planus. (*St. Petersb. Med. Woch.*, No. 44, 1881.)

21. Seseman, E. — On the Treatment of Psoriasis. (*Ibid.*)

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1. *Neisser on the Use of Naphthol in Skin-Disease.*—With regard to the use of naphthol in skin-diseases, as recommended by Dr. Kaposi (*Wien. Med. Woch.*, Nos. 22 and 23, 1881, and London Medical Record, Oct. 1881, p. 413), Neisser (*Centralb. für die Medic. Wissen.*, No. 30, 1881), as a result of experiments on animals, warns that hæmoglobinuria may follow the absorption of naphthol when freely used, the danger being similar to that attending the free use of pyrogallic acid.

2. *Unna on the Treatment of Cicatrices.*—Unna has found (abstract in *Viertelj. fur Derm. und Syph.*, Heft 2 and 3, 1881, p. 499) the cicatrices of small-pox, and after ulceration, much improved in appearance by daily rubbing with fine sand. A small sponge soaked with soap-lather, is dipped in the powder collected from the *débris* of marble, and is then steadily rubbed over the cicatrix. The resulting improvement is attributed to the stimulating effect of the mechanical irritation.

3. *Lassar, Lewin, and Köbner on the Treatment of Eczema.*—In a discussion (*Berlin. Klin. Woch.*, Nos. 2 and 3, 1882) on the treatment of eczema, Lassar recommended, in acute eczema, the employment of a two per cent. carbolic oil. Lewin preferred the prepared muslin bandages of Unna, and specially recommended ergotine in chronic eczema. Köbner expressed an opinion that, valuable as ointments were in eczema, they were too exclusively used. He could not bear out Lewin's experience with ergotine. In a case in which he had tried it, patches of circumscribed eczema had remained stationary, with the exception of a few to which tar had been applied.

4. *Kohn on Trichorrhexis Nodosa.*—Kohn found (*Viertelj. für Derm. und Syphilis*, Heft 4, 1881) that the appearances in hairs so characterised are produced by desiccation of the centre of the hair, accumulation of air and consequent distension, and, finally, rupture of the cortical substance.

5. *Hebra on Rhinophyma.* — The enlargement of the nose, by some authors named acne hypertrophica, by Hebra rhinophyma, by Wilson spargosis, has been (*Viertelj. für Derm. und Syphilis*, Heft 4, 1881) histologically examined by Hebra. The enlargement is produced by an abnormal growth of connective tissue. The sebaceous glands are divided into lobules by growth of connective-tissue, and these

lobules enlarge. The author does not believe that the affection, as is commonly supposed, is due to the abuse of alcohol. The treatment he had found most successful is excision of the hypertrophied parts. The deeply situated portions of epidermis, between the sulci of the growth, are not entirely removed by this operation, and form so many epidermic islands, from which the new epidermis rapidly grows.

8. *Pellizzari on certain Eruptions of the Skin, produced by the Pathogenic Action of Iodide of Potassium.*—Pellizzari (*Archives of Derm.*, No. 3, 1881) describes two remarkable and rare cases, in which the administration of iodide of potassium was followed by large deep-seated tumours in the subcutaneous cellular tissue. Large bullæ covered the seat of abscesses of the fore-arm and left thigh, and left deep sores, which soon filled up with granulations. The patients were syphilitic. The iodide produced considerable constitutional disturbance; and its association with this condition, and with the nodules, was shown by the reappearance and disappearance of the symptoms, according as the medicine was given or discontinued.

9. *Stilwagon on a case of Phthiriasis Palpebrarum.*—A girl aged 11 years (*Archives of Derm.*, No. 3, 1881), presented the appearance as if she were suffering from an ordinary eczematous condition of the edges of the lids. The eyes were, in places, slightly crusted, in others scaly, and in some parts normal. Nits were observed on the lashes, and minute reddish specks, the excrement of the pediculi, on and beneath the lower lids. The pediculus was small, and belonged to the pubic variety.

10. *Hebra on a case of Congenital Defect of the Cutis.*—An otherwise well-formed child presented at birth an arrest of development of the skin on both sides of the head. The largest area of imperfect development was on the left side, and was two and a third inches long, and from one-fifth to half an inch in breadth. The patches were covered by a tender, transparent, partially folded, and very pliable membrane, beneath which a serous fluid had accumulated, which could be readily displaced.

11. *Bulkley on a case of Lichen Planus affecting the Penis before developing elsewhere.*—In this case (*Archives of Derm.*, No. 4, 1881), an eruption of lichen planus appeared first on the glans penis and inner surface of the prepuce; a few weeks afterwards just below the right knee, and, finally, on the backs of the hands and arms.

12. *Robinson on the Anatomical Seat of the Parasite in Tinea Tonsurans Capillitii.*—Dr. Robinson (*New York Med. Jour.*, vol. 33, p. 289) examined, microscopically, skin from the scalp affected with tinea tonsurans. He found that, in the rete Malpighii, both spores and mycelia were present, and, in the corium, that spores were found in varying quantity, isolated, grouped, or arranged in rows. [These conclusions are in direct variance with the results of examinations brought before the Royal Medical and Chirurgical Society by Dr. Frederick Taylor and the reporter.—*Rep.*]

13. *Goldsmith on Pigeon-Lice Infesting the Skin.*—A woman consulted Dr. Goldsmith on account of her skin being infested by very minute insects, which appeared when she sweated. Dr. Goldsmith witnessed the fact. When perspiration was induced, he observed that small black or brownish insects emerged singly, in pairs, or in triplets, from numerous points. After the sweating ceased, the insects, as the woman had asserted, 'crowded into her skin again'. The points where they entered and emerged were the sweat-pores. The lice were communicated from pigeons, which nested in her garret, and which she frequently handled. She got quit of the pigeons, rubbed her skin with sulphur powder, boiled her clothes, and had no further trouble with the pigeon-lice. Two other cases are referred to.

14. *Besnier on a Tumour of the Skin which was Clinically a Cancer, but Histologically doubtful in its Nature.*—A man, aged 49 (*Annales de Dermat. et de Syphilig.*, 2me séries, vol. ii, No. 4), noticed in the beginning of 1877 that there were several small enlargements on his back, which were at first discrete and then fused into groups, and eventually became ulcerated at several points. When seen by Besnier, in June 1878, the dorsal region was occupied by two considerable tumours; one irregularly oval, measuring 14 centimètres by 5; the second, round and fungoid, measuring 7 centimètres by 8. Both were considerably elevated, being raised from 2 to 4 centimètres above the level of the surrounding skin. The surface was unequal and nodulated, and the summits of many of them broken down by ulceration. The colour of the non-ulcerated parts of the tumours was a violet-red. The man felt well, ate well, slept well, and had no pain in the affected parts; and although the tumours occupied a considerable extent of the dorsal region, he could lie on his back without discomfort. There were no cicatrices and no enlarged glands. Clinically, M. Besnier diagnosed the growths as cancerous; but, it being recognised that their nature was open to doubt, portions were excised and examined by MM. Malassez and Chambard. The result of this examination seems to have only increased the doubt. At the periphery of a nodule, in the diffused and ill-defined zone separating it from the healthy tissues of the skin, lymph-cells were found in small numbers between the connective tissue bundles. Towards the centre of the nodule, the cellular collections become larger, and separated the bundles more widely. In the centre of the nodules these lymph-cells (*cellules lymphatiques*) were confluent and compressed against each other, the connective tissue being reduced to a few delicate finely granular and very friable fibrillæ. Blood-vessels were still found in the nodules, and from their walls projected fine fibrillæ, communicating with those which were amongst the cells. The learned histologists who examined the tumour considered that the neoplasm was either a granuloma or a lymphadenoma. M. Besnier remarks that on clinical grounds the idea of a granulation tumour must be rejected, whilst that of a lymphadenoma might be accepted. [Excellent coloured plates illustrate the paper, showing the appearance of the tumours, and also representing the microscopic appearances. Tumours nearly resembling the one in question have been brought before the Pathological Society of London during the last few years, and have given occasion to the expression of considerable difference of opinion. The reporter has found similar histological appearances in the new growth that gives its special characters to the affection known in England as rodent ulcer or rodent cancer, and has considered the neoplasm epithelial in its nature, even when the cells, as in the present case, were constituted by a small round nucleus and a very faint zone of protoplasm. Small elastic fibres and blood-vessels are found in the midst of the neoplastic cells in rodent cancer. Compare *Path. Trans.*, vol. xxx, pl. 24, and woodcut, p. 382; vol. xxxi, pl. 13 and 14; and vol. xxxii, pl. 29, figs. 4-7 —*Rep.*]

15. *Cornil and Suchard on the Seat of the Parasites of Leprosy.*—The authors (*Ann. de Derm. et de Syphil.*, 2me serie, vol. ii, No. 4) confirm the observers who have found a bacillus in leprosy. They find the parasite plentifully in the cells which form the characteristic histological feature of leprosy, but they do not find it in the cells of the epidermis. They infer that the epidermis, so long as it remains entire, prevents the diffusion of the specific element, and thus so far is a barrier against contagion.

18. *Hardy on Pellagra.*—M. Hardy showed to the French Academy of Medicine (*Ann. de Derm. et de Syphil.*, 2me série, vol. ii, No. 4, p. 719) the hand of a patient who had died of pellagra. The man had been a drunkard, and had never eaten maize. M. Hardy believes that alcoholism is a cause of pellagra; MM. Th. Roussel, Lancereaux, and Noël Gueneau de Mussy, on the other hand, stating their belief that pellagra is a specific malady always due to altered maize.

19. *Déjerine on Changes in the Cutaneous Nerves in Pellagra.*—Déjerine made (*Gaz. Hebd.*, Nos. 26, 27, and 29) a histological examination of the nerves of the skin in two patients who died of pellagra in the service of M. Hardy, and found a great number of the nerve-trunks represented by empty sheaths.

20. *Pospelow on Lichen Ruber Planus.*—Pospelow (*St. Petersburger Medicin. Woch.*, No. 44, 1881) describes a case in which the eruption of lichen ruber planus was present on the tongue and mucous membrane of the hard palate and gums. The eruption was freely out on the skin of the trunk and limbs. [The author also refers to a case of Neumann's, in which the eruption was present on the mucous membrane of the mouth as well as on the back.] In regard to the etiology of the disease, he remarks that, in five out of six cases of lichen ruber that came under his observation, the eruption appeared after a rapid cooling of the whole cutaneous surface.

21. *Seseman on the Treatment of Psoriasis.*—To avoid the inconveniences attending the use of chrysarobin (chrysophanic acid) in psoriasis (extension of inflammation to the surrounding skin, etc.), Seseman (*St. Peters. Med. Woch.*, No. 44, 1881) employs a solution of 10 grains of chrysarobin in 1 drachm of collodion, with which the patches of psoriasis are painted every second day. Twice a week the patient is allowed to take a bath, and, if the skin seem very dry, to rub in simple ointment. G. THIN, M.D.

OPHTHALMOLOGY.

RECENT PAPERS.

1. SCHWEIGGER. — Strychnia Treatment and Hysterical Amblyopia. (*Klin. Monats. für Augenheilk.*, Nov. 1881.)

2. KRŒMER. — Antiseptic Atropine and Eserine Solutions. (*Klin. Monats. für Augenheilk.*, Nov. 1881.)

3. VOSSIUS. — Treatment of Diphtheritic Conjunctivitis. (*Klin. Monats. für Augenheilk.*, Nov. 1881.)

4. GALEZOWSKI.—Statistical Review of Clinical Work. (*Recueil d'Ophth.*, Nov. 1881.)

5. GALEZOWSKI. — On Thrombosis of the Retinal Vessels in Ophthalmic Migraine. (*Gaz. des Hôp.*, Dec. 6, 1881.)

1. *Schweigger on Strychnia Treatment and Hysterical Amblyopia.*—Schweigger urges that, in hysterical amblyopia and colour-blindness, the loss of visual functions exists only in the imagination of the patient. In several cases of this nature, he was able to prove that it was not real (*Klin. Monats. für Augenheilk.*, Nov. 1881). A girl, aged 14, with hypermetropia and deficient convergent power, stated at her second visit that the right eye had rapidly lost all perception of light. The pupil reacted to light, and, when tested by prism and stereoscope, it was manifest that the 'blind eye' had good vision. There was no appearance of intentional simulation, and there were no other signs of hysteria. No incredulity was expressed to the patient, and the case was exhibited at the clinic as one which strychnia injections would cure. Subcutaneous injections of distilled water were given, and sight returned gradually and completely in about three weeks. In this case there was neuro-retinitis in each eye, which persisted after the recovery of vision. Another hysterical patient complained of colour-blindness in the left eye; with this eye all colours were seen gray, with the other they were seen correctly. The stereoscope proved that the statement was incorrect. A small piece of coloured paper, placed in the right half of the left visual field, was correctly seen, the patient imagining that she saw it with her sound right eye. Conversely, a piece of coloured paper, placed in the left half of the right visual field, was seen gray, because the patient imagined she saw it with her left, or colour-blind, eye. A third case is mentioned, in which the patient professed to be unable to see the hand before the face, and yet was able to walk about freely without running against the objects in her path. An extreme and persistent convergence of the optic axes, which could not be effected voluntarily for the sake of simulation, occurred at the same time as the alleged loss of vision. There are many cases of simulated blindness, says Schweigger, in which there is no intentional deception. The patient's consciousness is overruled by the idea that she cannot see. In the monocular form, the artifice which the surgeon must employ, for the purpose of detection, consists in presenting the object to the supposed blind eye in such a way as to make the patient believe that it is seen with the sound eye.

2. *Kroemer on the Employment of Antiseptic Atropine and Eserine Solutions.*—The writer is of opinion that the conjunctival inflammation, which is sometimes set up by the use of atropine, is a septic process due to the formation of fungoid growth in solutions which have been long kept (*Klin. Monats. für Augenheilk.*, Nov. 1881). He found that the addition of salicylic acid to an atropine solution did not prevent it from becoming turbid: that boracic acid had only a slightly preservative effect; but that carbolic acid, in the proportion of 1 in 1,000, kept it perfectly clear. Solution of eserine, also, was found to remain clear and almost colourless when treated in the same manner. This proportion of carbolic acid is stated to produce no disagreeable sensation in the eye, and it is said that, since the introduction of these antiseptic solutions, in the clinic at Basle, conjunctivitis from atropine, which was formerly of frequent occurrence, has not been seen.

3. *Vossius on the Treatment of Diphtheritic Conjunctivitis.*—Guided by the success obtained by Professor Bose in the treatment of diphtheria of the throat and of wounds, by means of a four per cent. solution of salicylic acid in glycerine, Vossius employed the same application in a bad case of conjunctival diphtheria, and with unexpectedly good results (*Klin. Monats. für Augenheilk.* Nov. 1881). Applications of ice and frequent cleansings with solutions of carbolic, boracic, and salicylic acids, had

been used without benefit. There were great chemosis and swelling of the lids, with extensive ulceration of the cornea. The glycerine solution of salicylic acid was painted every half hour upon the conjunctiva; improvement commenced at once, the swelling subsided, and the corneal ulceration healed. The eye recovered completely from what had been, to all appearance, an almost hopeless condition. It was noticeable that the stage of purulent discharge, through which such cases commonly pass, was absent in this intance, and that the very extensive and dangerous ulcer of the cornea healed without leaving any scar sufficient to cause impairment of vision. The patient was a little girl aged two years; the diphtheria affected the fauces in the first instance, the eyes later.

PRIESTLEY SMITH.

4. *Galezowski on a Statistical Review of Clinical Work from July* 1, 1880, *to July* 1, 1881.—In this paper (*Recueil d'Ophthalmologie*, Nov. 1881), Dr. Galezowski reviews a portion of the clinical work accomplished by him last year. In considering the subject of treatment of ophthalmia neonatorum, he maintains that, of all remedies which have been hitherto recommended, nothing surpasses a solution of nitrate of silver, of a strength of 1 in 40. This should be applied to the conjunctiva night and morning, the excess being neutralised with sodic chloride in the usual manner. This strength is recommended in preference to one either greater or less, inasmuch as the former would be too violent, the latter too feeble. The important point in treatment is to apply the remedy twice a day, so as to keep the parts constantly under its influence. By this method Dr. Galezowski has, within the last six years, treated more than four hundred cases of ophthalmia neonatorum, without a single failure or loss of vision. He considers it almost a specific. Should much chemosis continue after the suppuration has ceased, its absorption may be hastened by mild scarifications. In gonorrhœal ophthalmia in adults, Dr. Galezowski recommends the use of a similar solution, viz., 1 in 40, aided by injections, eight or ten times a day, of a solution of 1 in 1000, coupled with the use of eserine, depletion, and carbolised spray. In granular ophthalmia, he uses the ordinary remedies, with the exception of acetate of lead, which, he considers, should be wholly abandoned. It is very liable to form precipitates, which, lodging in the minute spaces between the granulations, act as foreign bodies, causing irritation and ulceration of the cornea. A case is recorded of serous chemosis of the conjunctiva from the excessive use of iodide of potassium. The patient had taken 30 grains daily of this salt during a long period, and suffered from all the local manifestations of iodism. Another case is mentioned of an abscess of the cornea in a night watchman, which was traced to the influence of very low temperature. Two cases are given, which illustrate the influence of irritation of the dental nerves on other branches of the fifth. The first was that of a child aged two years, who suffered from photophobia, kerato-conjunctivitis, and abscess of the cornea, all which symptoms disappeared as soon as the canine teeth had pierced the gum. The second case was in a child aged 30 months, and was, in the main, similar to the first. As regards interstitial keratitis, Dr. Galezowski holds that there are two distinct forms of the affection, one strumous, the other syphilitic. The former generally commences as an irregular spot, and progresses from the centre of the cornea towards the periphery. The latter, on the contrary, generally spreads from the periphery to the centre. Its cure can be expedited by the use of steam-douches, and sometimes of iridectomy. He instances cases in which this treatment has given good results, as also that with the albuminates and peptonates of mercury, either rubbed in or injected hypodermically. In herpes of the cornea, Dr. Galezowski has found a good deal of benefit from graduated compression. This he applies by means of an elastic bandage, manufactured for him by M. Galante of Paris, expressly for the purpose.

5. *Galezowski on Thrombosis of the Retinal Vessels in Ophthalmic Migraine.*—M. Galezowski, in a communication to the meeting of the Société de Biologie, on Nov. 26, reported in the *Gaz. des Hôp.* for Dec. 6, said that in 1877 he first demonstrated that ophthalmic migraine is characterised by periodical visual disturbance, hemiopia, scintillating scotoma, with luminous zig-zag, which last from a quarter to half an hour. There presently ensue headache, nausea, vertigo, accompanied sometimes by symptoms of aphasia, pains in the arms or legs, momentary loss of memory, etc. When the attack is once over, the sight is restored to its normal condition; but at the end of one or two weeks, or one, two, or six months, the same crisis re-appears. According to all probability, the case is one of spasmodic contractions of the vessels of the brain and the retina by a neurosis of the vaso-motor nerves. But the frequency of these crises may, in a certain number of these diseases, give rise to obliteration of the vessels and to thrombosis. M. Galezowski has, in fact, up to the present met with this lesion in three of his patients attacked with ophthalmic migraine. In one case a young girl, aged 15, suffered with ophthalmic migraine from the age of seven or eight, and, in one of these attacks, she permanently lost the sight of one eye, in consequence of a retinal thrombosis, presenting all the characteristics of an embolism, but without any cardiac lesion. He met with two similar cases in which the ophthalmoscope showed the presence of a thrombus. A fourth case is still more interesting. A woman, aged 29, lost the sight of one eye in one of the attacks of ophthalmic migraine and aphasic symptoms, etc. The ophthalmoscope revealed partial atrophy of the papilla of one eye; and, in all probability, in this case there was thrombosis of the cerebral vessels. In fine, the researches and cases reported by M. Galezowski bring out the important point that ophthalmic migraine, which has been hitherto looked upon as a purely nervous affection, may, although exceptionally, give rise to obliterations or thromboses of the arteries either of the retina or of the brain.

LITTON FORBES.

TOXICOLOGY.

RECENT PAPERS.

1. CLARKE, T. F.—Cantharides as a Cumulative Poison. (*Lancet*, vol. i, 1881, p. 499.)

2. LUDWIG.—Chlorate of Potassium. (*Jour. de Pharm. et de Chemie*, Sept. 1881.)

3. ZUR NIEDEN.—Poisoning by Carbolic Acid. (*Berl. Klin. Woch.*, No. 48, 1881.)

4. LEHMANN, V.—Detection of Poisonous Metals in the Animal Organism. (*Zeitschr. fur Physiol. Chimie*, Nov. 5, 1881.)

5. TESTA.—The Alleged Antagonism between Amyl-Nitrite and Chloroform. (*Gaz. Med. Ital.*, Oct. 29 and Nov. 5, 1881.)

6. Schultz.—The Parallelism in the Actions of Coniin and Curare. (*Zeitschr. für Klin. Med.*, Band iii.)

7. Delaunay.—Influence of Nutrition on Poisoning by Strychnia. (*Acad. des Sciences de Paris.*)

8. Smith.—Chloral in Belladonna-Poisoning. (*Lancet*, Oct. 1881, p. 589.)

9. Henner.—Tin-Poisoning from Preserved Meats and Vegetables. (*Ibid.*, p. 607.)

10. Smith, F. Porter.—On a somewhat Unusual Source of Lead Poisoning. (*Ibid.*, p. 779.)

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1. *Clarke on Cantharides as a Cumulative Poison.*—Mr. T. F. Clarke (*Lancet*, 1881, vol. i, p. 499) relates two cases exhibiting apparently a cumulative action of cantharides when administered in small medicinal doses for the cure of gonorrhœa. In the first case, the patient had been taking a mixture for three days, each dose of which contained five minims of the tincture of cantharides. One week after the cessation of the use of the drug strangury set in, and lasted four days. In the second case the patient, after taking two doses only of a similar cantharides mixture, had some of the symptoms of poisoning, viz., frequent desire to micturate, and burning pain during micturition, which was very difficult, and always accompanied towards the end of the process by a few drops of blood. Notwithstanding the continuance of the five-minim doses of tincture of cantharides three times a day, the symptoms rapidly subsided.

2. *Ludwig on Chlorate of Potassium.*—Ludwig (*Jour. de Pharm. et de Chemie*, Sept. 1881), having investigated a case of poisoning by this salt, has arrived at the following conclusions. Potassium chlorate appears to act, on the one hand, like phosphorus and arsenic; it is reduced by the blood to the state of potassium chloride, for it can be detected neither in the blood nor in the urine, nor even in the gastric contents; the red corpuscles are destroyed, and other toxic symptoms are developed. On the other hand, the chlorate is decomposed in the kidneys by feebly acid urine into a base and an acid, and the chloric acid thus formed acts in an energetic manner. This singular alleged fact is in opposition to the received views of chemists.

3. *Zur Nieden on Poisoning by Carbolic Acid.*—A case of poisoning by carbolic acid admitted into the medical clinic at Freiburg is detailed by P. zur Nieden (*Berl. Klin. Woch.*, 1881, No. 48), and is of unusual interest, since the patient, a robust woman of 30, swallowed an alcoholic solution of carbolic acid containing 35.8 per cent. of phenol, and recovered. It was ascertained that 12.9 grammes, or nearly half a fluid ounce, of carbolic acid was swallowed, of which 6.7 grammes were subsequently washed out of the stomach; but at least 6 grammes, or about a fluid drachm and a half of phenol, must have been absorbed. Hæmoglobinuria set in within an hour of the ingestion of the poison; and that the urine contained hæmoglobin, was determined by the spectroscope, but no red corpuscles were detected in the secretion. Eight and a half hours after the taking of the phenol, hæmoglobin was no longer detectable in the urine, though a phenol reaction remained for two days. The most prominent symptoms were insensibility within ten minutes, dizziness speedily passing into profound coma, contracted pupils, irregular breathing, irregularity of pulse, extreme cyanosis, vomiting, and depression of temperature (temperature in an hour and half 34.4 deg. Cent. or 94 deg. Fahr). The chief interest of the case lies in the acute hæmoglobinuria.

4. *Lehmann on the Detection of Poisonous Metals in Animal Organisms.*—Victor Lehmann (*Zeitschr. für Physiol. Chem.*, Nov. 5, 1881) publishes an essay 'On the Best Method of Detecting Lead, Silver, and Mercury in Animal Organisms after Death'. He finds lead in nearly all organisms and secretions after administration of the salts of lead, even such as are with difficulty soluble, such as the sulphate and phosphate. These are more or less absorbed from the alimentary canal. Insoluble salts, such as lead sulphate, are, however, not absorbed. Silver was found in the urine, fæces, bile, and in other organs. The salts undergo reduction after absorption, and the metal is deposited in the organs, as in cases of argyrism. Mercury was found in all the organs and secretions of the body, after the administration of its preparations. Even such insoluble salts as calomel are absorbed; but in what way was not definitively ascertained. Calomel, however, passes into the lower bowel, chiefly as sulphide, and is excreted in that form in the fæces. To effect the complete separation of lead from the tissues, a previous destruction of the organic matter is necessary. The most delicate test for this metal is sulphuretted hydrogen, by means of which 0.01 per cent. of the metal may be detected, if the solution be alkaline. In the absence of organic matter, nevertheless, lead may be as completely separated by electrolysis as by sulphuretted hydrogen. When the tissues or organic fluids have to be tested for silver, these must first be fused with soda and potassium nitrate, the fused mass lixiviated with water, the residue dissolved in nitric acid, filtered, the filtrate evaporated to a small bulk, and tested for silver with hydrochloric acid, which produces a turbidity with one half to one-fourth per cent. of silver nitrate. The best method for detecting traces of mercury in urine and tissues is that of Mayer, which consists in distilling in a current of steam. By this method one part of the metal may be detected in 10,000 of urine. The electrolytic method of Schneider is more convenient, but not so delicate. The mercury is previously converted into iodide when one part of mercuric chloride may be detected in 1,000 of urine. T. Stevenson, M.D.

5. *Testa on the alleged Antagonism between Amyl-Nitrite and Chloroform.*—In this paper Dr. Testa (*Gaz. Med. Ital.*, Oct. 29 and Nov. 5, 1881) gives the results of forty-four carefully conducted experiments on the action of amyl-nitrite in presence of chloroform in animals. The subjects of the experiments were rabbits, and the experiments themselves are divided into four series of eleven each. In the first series the action of chloroform alone is studied; in the second, the influence on the anæsthetic condition of amyl-nitrite; in the third, the influences of varying doses of chloroform; in the fourth, the influence of the amyl-nitrite on arterial pressure. From these experiments, Dr. Testa concludes that the action of amyl-nitrite is to lower arterial tension, to increase the heart-beats, and to render respiration irregular. He believes that its action in chloroform poisoning is not only useless, but positively pernicious, inasmuch as it intensifies the very risks to which chloroform itself is liable. There is, therefore, no true antagonistic or antidotal action between the two substances.

Litton Forbes.

6. *Schulz on the Parallelism in the Action of Coniin and Curare.*—This writer has been induced by the great differences in specimens of curare and

curarin to experiment with hydrobromate of coniin as a substitute (*Zeitsch. für Klin. Med.*, Band iii). The effect is similar; paralysis of the motor nerve extremities with slight muscular contractions, as with curare. The heart's action persists to the end; the nerve-centres are not directly affected; and the sensorium, as in the well-known case of Socrates, remains clear till shortly before death. The hydrobromate is readily soluble in water, and keeps better than the pure alkaloid.

JAMES ANDERSON, M.D.

7. *Delaunay on the Influence of Nutrition on Poisoning by Strychnia.*—M. Delaunay has presented to the Académie des Sciences (meetings on Aug. 29 and Sept. 5) the result of experiments made with the assistance of M. Wiet regarding the influence of the greater or less intensity of nutritive phenomena on strychnia-poisoning. *Constitution.*—On injecting the same dose of strychnia into two frogs, one of which was large and vigorous, and the other small and feeble, the phenomena of poisoning were seen to be much more rapid, and particularly more intense in the first than in the second. In the case of recovery, the stronger frog recovered before the more feeble. *Alimentation.*—A frog, which had always been well nourished, was more sensitive to the action of the poison than an anæmic frog, which had been starved for some weeks. *Muscular Power.*—On injecting the same dose of strychnia into two frogs of the same size, one of which moved and hopped for half an hour, it was seen that the latter was sooner and more seriously poisoned than the other. *Position.*—Regarding the position held by the animal; if the same dose of poison were given to two frogs, one of which was suspended by the head and the other by the feet, it was seen that convulsions affected the frog with the head low twenty minutes before the other, and were much more intense. The author is led to believe that the horizontal position may be a cause of death in individuals seriously poisoned, and he questions if it would not be good to maintain them in a vertical position—the head high and the feet low—by placing them in a special apparatus. *Hæmorrhage.*—If the same dose of strychnia were given to two frogs, one of which was previously enfeebled by hæmorrhage, it was seen that the latter was less rapidly and less seriously poisoned than the frog which was untouched. From the therapeutic point of view, if, after having equally poisoned two frogs, one of them were bled, it were seen to return to a normal condition whilst it lost blood. It is known, from the researches of M. Ch. Richet, that large doses of strychnia kill without producing convulsions. If a frog thus poisoned were bled, tonic convulsions, which characterise the first degree of poisoning, were produced in it. *Congestion.*—If congestion were produced in the foot of a frog by burning it with nitric acid, or by inserting pins in its palmar surface, this foot was seen to become convulsed before the other, and the convulsions were also more violent.

8. *Smith on Chloral in Belladonna-Poisoning.*—In the *Lancet*, Oct. 1881, p. 589, Dr. Protheroe Smith reports a case of belladonna-poisoning from inadvertence, the dose being from half an ounce to an ounce of the liniment, which was taken at 5 A.M. The lady was seen at 9 A.M., and a mustard emetic caused free vomiting. She was treated with opium, stimulants, and food. Next day, at 11 A.M., she remained still incoherent, restless, but with a fuller pulse. At this time, half a drachm of chloral-hydrate was given. In half an hour she regained consciousness, and, after enjoying a refreshing night's rest, was next day quite herself again.

9. *Henner on Tin-Poisoning from Preserved Meats and Vegetables.*—Mr. O. Henner, in the *Lancet*, Oct. 1881, p. 607, gives a summary of his examination of a large number of tins of all kinds of meats and vegetables. With the exception of some sausages, all the samples contained more or less tin, many to a very large extent. One of the soups contained 35 milligrammes of tin, one of the condensed milks 8 milligrammes. Tin prevents the lead of the solder from passing into solution; it completely precipitates lead from its solution, an equivalent quantity of tin being taken up. Experiments on animals have proved that stannic compounds are harmless, but that tin, in the stannous condition, is a virulent poison. These facts demand attention, and make it desirable that another substance should be employed to form the receptacles of preserved meats and vegetables.

10. *Smith on a somewhat Unusual Source of Lead-Poisoning.*—Mr. F. Porter Smith draws attention (in the *Lancet*, Oct. 1881, p. 779) to the fact that wine may be contaminated with lead from some of the shot used in washing the bottles being allowed to remain.

R. NEALE, M.D.

REVIEWS.

The Other Side of the Opium Question. By W. J. MOORE, L.R.C.P., M.R.C.S., L.S.A., Deputy-Surgeon-General H.M. Forces, Presidency Division, Bombay, Honorary Surgeon to the Viceroy of India. London: J. and A. Churchill. 1882.

THE agitation on the so-called opium question continues to excite such interest, that reliable addition to our knowledge of the subject will be read with avidity. Deputy-Surgeon-General Moore is already well known as an authority on the subject, and the re-issue of the papers which recently appeared in the *Indian Medical Gazette* will be welcomed by a large circle of readers. In the February number of the *Nineteenth Century*, Mr. Storrs Turner asserts that no French or German medical man, no single Chinese authority, can be quoted to testify to the innocence of opium; and that there is no country in the world in which the habitual use of opium is regarded as anything but a dangerous vice. In Mr. Moore, he will find an uncompromising opponent, who considers that the moderate use of opium is not only legitimate, but, under many circumstances, beneficial both in health and disease.

The 'effects of opium', as depicted by non-professional writers, are familiar enough to us all. Thus Sirr says, 'Physically, the effects of opium on the enslaved victim is almost beyond the power of language to portray. It not only enslaves its votaries, but destroys their bodies, and commits such fearful ravages in its progress, that the mental powers are wholly paralysed, and the consumers are conducted onwards from one crime to another. The habitual use of this drug terminates the smoker's life in about five years, and he may readily be identified by his lank and shrivelled limbs, tottering gait, sallow visage, feeble voice, and death-boding glance of his eye. These are so superlative in their degree, and so closely blended in their union, that they at once bespeak him to be the most forlorn creature on the

face of the earth.....A few days of this fearful luxury, when taken to excess, will impart a pallid and haggard look to the features ; and a few months, or even weeks, will change strong and healthy men into little better than idiot skeletons. The pain they suffer on days without the drug, after long habit, no language can explain.' It must be admitted that the effects of an excessive use of opium are scarcely exaggerated in this description ; indeed, the fact that opium eventually induces bowel complaints, such as diarrhœa and dysentery, and that it is the frequent cause of rheumatic pains, might have been added to complete the sensational picture ; but that such results follow other than the excessive use of opium is not true. The career of a drunkard has been sketched in quite as forcible a manner, but not even the most enthusiastic teetotaller would affirm that the description of the drunkard is applicable to all who use fermented liquors. Then, again, there is reason to believe that the maladies for which opium is taken have been regarded by unprofessional observers as diseases caused by opium. The Chinese, as is well known, are very subject to scrofulous sores, especially the poor and needy. Want and pain cause such persons to take opium. Casual observers, not being able to distinguish scrofulous sores from other ulcers, jump to the conclusion that they are due to the opium. Such, too, is the case with regard to skin-diseases and numerous other complaints, opium being credited with producing that condition for the relief of which it is taken.

It has been frequently stated that the habitual use of opium terminates life in about five years. This, according to our author, is absolutely untrue. He is personally and intimately acquainted with natives of India who have taken opium from boyhood, and who at forty, fifty, and even the grand climacteric of sixty-three, are as hale and hearty as any of their fellows. He speaks of a servant of his, who had been an opium-eater from his youth upwards. He contracted the habit in the first Afghan war ; but he marched thousands of miles, year after year, over the sandy deserts of Western Rajpootana. Although the opium-pipe was his only solace, he never neglected his work, or failed to appear at that unpleasant hour in the very early morning at which long marches rendered rising a necessity. Opium-smokers are found amongst some of the most physically powerful men in India, men who will ride their fifty, eighty, or even a hundred miles under the burning sun of the 'Land of Death', as Marwar, from its sterile sandy aspect, has been called. To the 'Kossid' obliged to travel long distances in a short space of time, opium is invaluable. The court 'hurkarus' are celebrated for the distance and speed with which they travel. They go without food and water, and they abjure sleep, being supported to their journey's end by an occasional pill of the opium they carry in a small box. When used by the impoverished 'ryot', it fills the void resulting from insufficient food, and affords him, not only a taste of that exhilaration of spirits which in other countries might be obtained from the use of alcohol, but enables him to undergo his daily fatigues with far less waste of tissue than would otherwise occur.

Again, we are told that 'atra cura' is the consequence of indulgence, that opium depresses the spirits, rendering its victim melancholy, and not unfrequently imbecile or even insane. Such, however, is not the case. De Quincey says :—'For ten years, during which I took opium, the day succeeding was always a day of unusually good spirits.' And he tells us that opium, instead of producing inactivity or torpor, often led him to frequent public places, such as markets and theatres. Doolittle says: 'Friends often invite each other to smoke opium as a preliminary to the discussion of business'—the reverse of our custom at home, where the glass usually follows business. It is hardly likely that the Chinese would use opium just before business discussions, if opium dulled the intellect.

Perhaps the worst feature about opium is the frequency with which it is given to children—a custom which prevails not only in China, but to a large extent in India also. Here, again, excuse may be pleaded, for the poor natives have not that opportunity which mothers in Europe enjoy of giving their children opium under the legalised patent-medicine guise of 'soothing syrups', 'cordials', or 'elixirs'.

On the whole, Deputy-Surgeon-General Moore has made out a very good case for 'the other side of the opium question', and his work is well worth careful perusal. William Murrell, M.D.

Elements of Practical Medicine. By Alfred H. Carter, M.D. London : H. K. Lewis. 1881.

We never take up a book of this kind without experiencing a feeling of uncertainty whether it expresses or fulfils any actual need. As a commencement, we try to place ourselves in the position of author, and to estimate the reasons of its matter and arrangement, and we confess to being unable to picture satisfactorily how it would be possible to set about such a book, and plan out the scheme for its accomplishment. Where to begin we should not know, and where to end would find us equally in hesitation, if not in despair. To many students, moreover (for whom we may assume it is intended), we do not think that the book will be helpful. If there be such a thing as a good memory—as distinct from a good understanding—that is to say, a power of remembering isolated facts stripped of many of their associations—to such it may appeal and find its service ; but to many others, we are persuaded, it will only be a dictionary of disease, and that necessarily an incomplete one.

These remarks will indicate the position which, we think, in the interests of medical education, books of this kind should occupy ; they should fulfil that part of the author's object which aims at providing the student with a general introduction to the study of medicine. At the very outset of his career, when going round the wards, any one may well take this volume in his pocket, and hearing for the first time terms employed, which are in an unknown tongue to him, he will find all the information he is capable of utilising at the moment, and of carrying away with him. *The Elements of Medicine* will be really useful under such circumstances. But when the author develops the remainder of his object as being to bring the essentials of the subject, 'so far as required for the ordinary medical qualification', within the grasp of those who are not disposed, or have not the leisure, to read the large and complete works, such as those of Aitken, Bristowe, Niemeyer, and Roberts ; and further expresses his opinion that this class of readers—more appropriately, we think, non-readers—meets with too little sympathy, we are bound to part company with him. Not altogether it is true ; for we hold, in common probably with the author, that the best education a student can obtain is to be got by taking a small text-book, and spending the difference of the time, with compound inte-

rest, at the bed-side. But the student who devotes himself to observation in the wards is not the one who has no time to read large books, if he be so minded. Ward work is no easy exchange for book work; it is a royal road of lengthy procession, of much toil; and we would venture to say that those who are not disposed, or have not the leisure, to read Bristowe or Roberts, ought to be cashiered at once; for if they hear not one of them, neither will they be persuaded to work in the wards.

Of the matter of this book we have nothing to say. Elementary works are always open to criticism, which is generally undeserving: for they are nothing if not dogmatic. We are disposed to look more at the work itself. We know that to write it must have been infinitely more troublesome than any larger book; and Dr. Carter appears to have fulfilled his purpose, so far as we can define it, with precision and discretion; and within the range which we have indicated it deserves success.

JAMES F. GOODHART, M.D.

Medical Electricity: A Practical Treatise on the Applications of Electricity to Medicine and Surgery. By ROBERTS BARTHOLOW, A.M., M.D. LL.D. London: Henry Kimpton. 1881.

PROFESSOR Bartholow is an excellent authority on this subject, and can boast of much practical experience, as well as extensive reading. He is a clear and practised writer, and his account of the principles of electro-physics, electro-physiology, and electro-diagnosis, is unusually compact and readable. His chapters on electro-therapeutics include a discussion of electricity in the treatment of cerebral affections, spasm, and cramp, the paralyses, pain, anæsthesia and analgesia, vaso-motor and trophic neuroses, constitutional diseases, and local, other than nervous, diseases.

The chapter on static electricity and its therapeutical applications is one of the least satisfactory in the book, the authors quoted being of older date, and no reference being made to the most recent applications of static electricity by the French school of electricians.

Reasonable development is given to the development of electricity in surgery; and, on the whole, we can recommend this little treatise in a very warm manner.

The Mother's Guide in the Management and Feeding of Infants. By JOHN M. KEATING, M.D. London: Henry Kimpton. 1882.

THIS excellent little treatise aims at supplying, in a more intelligent fashion, the want which used to be felt by the old monthly nurse. The mother who learns from this book how to watch nature, and how to fulfil the duties of the nursery, will be well instructed and self-dependent. Such subjects as the diet of the mother, bottle-feeding, choice of food, the bathing of children, the use of laxatives, and other general nursery rules, are treated with excellent judgment, and in concise and clear language.

A Manual of Ophthalmoscopy. By Dr. DAGUENET. Translated by C. S. JEAFFRESON, F.R.C.S. London: J. and A. Churchill. 1880.

THIS little book is intended, as its title-page denotes, for beginners in ophthalmology. It has the characteristic merit of all French books, that of being very clear and concise. The translation is well done. It is doubtful, however, if the word purple conveys to the English mind the exact idea of the colour employed as the second test (11*a*) in Holmgren's method for detecting colour-blindness. The account of optic neuritis is one of the best parts of the book; indeed, this commendation may be extended to the chapter on affections of the optic nerve generally. In respect of the remaining subjects treated, their brevity and precision will constitute their chief recommendation to English readers.

W. A. BRAILEY, M.D.

The Ophthalmic Review. Edited by KARL GROSSMANN and PRIESTLEY SMITH. London: J. and A. Churchill.

THE first number of this periodical publication, dated November 1881, is now before us. Its principal aim, as indicated in the preface, is to supply every month abstracts of the various recent articles, English and Continental. Numerous publications in German, French, and English—among the last of which we may rank our own, and among the former the *Centralblatt* of Hirschberg—cover the same ground. We may, however, welcome one more, and wish it success. Such publications cannot fail to be of service to those who wish, with little labour, to have a general acquaintance with the literature of the day.

W. A. BRAILEY, M.D.

Proposed Reforms in the Coroner's Office. By CLARK BELL, Esq. New York.

Address delivered before the Massachusetts Medico-Legal Society. By ROBERT AMORY, M.D. *Boston Med. and Surg. Jour.*, Nov. 22, 1881.

The Office of Coroner. Brit. Med. Jour., Jan. 14 and 21, 1882.

THESE papers contain interesting reviews of the modes adopted in various countries for holding inquisitions on dead bodies where death may possibly not have been the result of natural causes. Preference is given to the new system adopted by the Legislature of Massachusetts, in which State of the Union medical examiners have for all practical purposes superseded the old coroners. The medical examiners are required by law to be 'able and discreet men, learned in the science of medicine'. After four years' trial, Dr. Amory claims the following advantages for this new system. 1. The investigation of the cause of death after supposed violence is unattended with the disagreeable and harassing circumstances of partial publicity, which were necessary under the old coroner's system. 2. A more certain and definite knowledge of the cause of death is obtained. 3. An inquest is held under a magistrate, who presents his verdict without the inconvenience of a jury. 4. A written and detailed account is received from both medical and judicial examiners, which forms a more convenient record for use by the district attorney in presenting the case before the grand jury. 5. There is a financial saving to the treasury of the counties. 6. An opportunity for the study of pathological science is afforded.

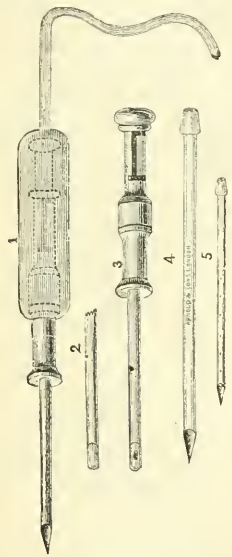
The pamphlet of Mr. Clark Bell, and the articles in the *Brit. Med. Jour.*, both contain details of the working of the Massachusetts system.

THOS. STEVENSON, M.D.

NEW INVENTIONS.

COUSINS'S NEW ANTISEPTIC TROCAR.

This new trocar, which is introduced to the profession by Dr. Ward Cousins, is a very simple and handy instrument. The special feature in its construction is that it is perfectly air-tight, and can be opened and shut within an India-rubber case (see Figs. 1, 2, and 3). It is composed of two metal tubes: the outer carries a pen-shaped lance, and the inner is round at the point, with a lateral opening. By a bayonet joint the trocar is opened and shut, at the same time the point of the lance is protected from injuring any internal part. The orifice and joints are introduced into the enlarged end of the India-rubber tube, which is slipped over a metal block, and then secured by a ring; and this serves for a handle to



the instrument. It is adapted for all kinds of tapping; it can be used also for exploring or injecting purposes; or it can be very readily attached to the exhausting apparatus of the aspirator. The trocar is manufactured by Messrs. Arnold and Sons of West Smithfield, in three convenient sizes.

Dr. Cousins states, in a medical contemporary, that he has employed it in every variety of operation, and with special advantage in cases of paracentesis thoracis, as the opening and closing action within the India-rubber ease is very readily accomplished, and the necessary movement can be easily performed by anyone after a little attention to the construction of the instrument. Fig. 4 represents a simple form of exploring tube to which an India-rubber bag can be adjusted. The capillary drainage-tube (Fig. 5) is intended for the treatment of anasarca; it can be left in the subcutaneous tissue without any risk of injury to the deeper parts, and its position can be altered without another puncture of the skin.

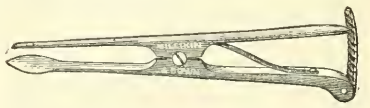
DR. WARD COUSINS'S EAR-PROTECTOR.

This simple little contrivance, of which we append an illustration, is admirably adapted for the use of those persons who require protection of the ear. Dr. Cousins's invention is an India-rubber, and consequently elastic, cushion, which is instantly adjusted

in the orifice of the external ear. It does not suspend the sense of hearing, but merely modifies or reduces the intensity of sound; and it also prevents a sudden shock of noise or cold upon the drum of the ear, which, in some temperaments, is followed by deafness, giddiness, and noise in the head. This ear-protector is especially adapted for swimmers, divers, and all who suffer from aural disturbance after bathing; and it will be found an efficacious remedy for such contingencies by all those who are daily working in the noise of factories, by soldiers or artillerymen exposed to the blast of cannon or fire-arms, and by sailors and travellers against severe cold and wind. It is made in five sizes, to suit the varying capacity of the auditory canal, is much more sightly than the inconvenient plug of cotton-wool frequently employed, is pleasant to sensation, and may be safely used by all persons who suffer from aural weakness and its attendant inconveniences. It is manufactured solely by Messrs. Lynch and Co., Aldersgate Street, E.C., and is practically everlasting in wear.

A NEW TRACHEOTOME.

Drs. Hale White and Walter Edmunds have designed a new knife for facilitating the operation of tracheotomy; they call it the tracheotome. One difficulty in the operation is always the introduction of the tube; the operator may pass it in front of the trachea, or miss his opening, and have to make a second, and may lose valuable time, and only suc-



ceed after several attempts. To obviate these difficulties, the knife shown in the accompanying cut has been devised. It resembles somewhat a pair of dressing forceps; at that end of the instrument which is to be introduced into the trachea, one of the blades has, at its lower half-inch, a cutting edge, and is shaped like an ordinary scalpel: the other, narrow and blunt, lies, when the instrument is closed, in contact with the cutting blade, and well behind its edge. At the handle the blades are widely separated, roughened to give the operator a better hold, and connected by a catch and spring, enabling them to be fixed at any degree of approximation. The method of using the instrument is as follows. The trachea having been exposed, either by the cutting edge of this instrument, or an ordinary scalpel, the instrument is held, with the cutting edge upwards towards the patient's chin and the trachea

opened in the usual manner, the instrument is held in position, and its two handles are pressed together, and the two blades thereby separated, thus widening the tracheal opening, the catch holding the handles in the position to which they have been brought. The patient can now breathe easily. The trachea being held widely open by the 'tracheotome', the child should be allowed to expel any membrane it can, and the surgeon has ample opportunity of inspecting the back of the trachea, and of removing any loose membrane seen lying there. An ordinary tracheotomy tube can now be introduced with the greatest ease between the two widely-separated blades in the trachea, and they can be withdrawn as soon as the tube is in position. The advantage claimed for this instrument is that the operator never loses his hold on the first opening he makes in the trachea. It is made by Messrs. Millikin and Down.

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A NEW URETHRAL BOUGIE.

Dr. A. Van Derveer of Albany, New York, writes, in the *New York Med. Rec.* of Dec. 1, 1881: — 'Having had excellent results from the use of the instrument illustrated by the accompanying cut, I feel it proper to call the attention of the profession to it. In the treatment of urethral stricture by gradual dilatation, and in those cases where it became necessary to maintain the calibre of the urethra after internal urethrotomy, or rapid divulsion, I have realised for a long time that the fixed curve of the steel sound gave unnecessary pain, and that the soft olive-pointed bougie, by passing two or more inches farther into the bladder than was required, gave to that organ a shock and an irritation which, in addition to being very disagreeable to the patient, incurred also the dangers of possible cystitis, with its complications.

'Acting upon the knowledge of the fact that we seldom, if ever, meet with a stricture in the prostatic portion of the urethra, I had made, two years ago, by Messrs. Tiemann and Co., light metal urethral dilators, of the average length of the spongy and membranous portion of the urethra—about eight inches—and in sizes ranging from Nos. 10 to 42 of the French scale. These were found very serviceable, being used by patients with safety and success. Later, as an improvement on the above described instrument, I had made, in different sizes, the solid rubber urethral bougie, which gives the least possible pain on passing. These bougies were also made by Tiemann and Co., who are now prepared to furnish them singly or in sets.

'Believing them to be the safest of all bougies, and knowing from actual use that they are the most serviceable, I present them with confidence to those of my brethren who have cases, in the treatment of which such an instrument is indicated.'

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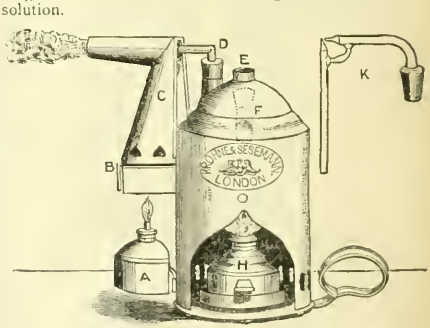
A NEW MERCURIAL SPRAY AND FUMIGATOR, AND UNIVERSAL STEAM INHALER.

The accompanying woodcut represents an inhaler, which Mr. Francis G. Hamilton, Assistant-Surgeon to the Central London Throat and Ear Hospital, has been using for more than two years, both in private and in hospital practice. He originally designed it for a case of severe relapsing syphilitic ulceration of the vocal cords, which refused, for more than three years, to yield to any of the ordinary methods of treatment used in such cases. The result has been most satisfactory, the patient's larynx remaining quite sound up to the present time.

In the illustration, G is the boiler, H the lamp for heating it, and E a tube which passes through the boiler to its under surface, in order that an increased heat-area may be obtained. F is a small tube, closed by a cork, through which the boiler is filled; and it is placed on one side of the boiler, so that, should the cork by any chance blow out, the water and steam would not come in the face of the patient using the instrument. D is a 'knee-tube', passing into the boiler through a movable vulcanite cork; and the point of the tube, through which the steam from the boiler comes, projects only a short distance, and through a largish opening, into the sublimer C. B is a small drawer, forming the floor of the sublimer, and on which the calomel is placed. A is the lamp for subliming the calomel, or other drug used. Both D, C, and A are easily removed; and, if steam and mercurial vapour be not required, but a Siegle's spray, it is only necessary to remove them, and put the glass tubes marked K in the place of D, and the long limb of K in a bottle containing the medicated solution.



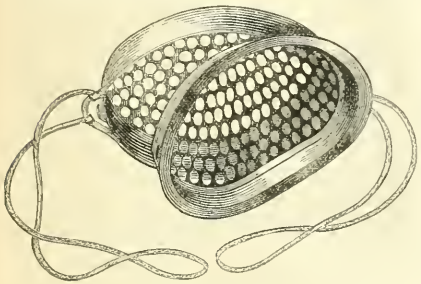
There are some precautions necessary in using calomel inhalations. 1. The calomel should be resublimed calomel, and not such as is ordinarily used internally in medicine. This is important, as the ordinary calomel is often very irritating for inhalation, owing to the impurities which it contains. 2. The quantity of calomel used should at first only be small, about two to five grains; and it can afterwards be increased to ten grains, if necessary. 3. The patient should never be urged to use more than he can bear without much coughing, and this is especially the case on first using it, when it is as well that he should not take more than two, three, or four inspirations; and, after a day or two, he will be able to tolerate it much better. In using the instrument, the lamp A should not be lighted until the steam is coming off freely from the boiler, or the steam may be dried off as it is emitted, so as to get a dry instead of a moist inhalation, which, in the experience of Mr. Hamilton, is far more irritating.

It will be seen at once that the apparatus can be used as a local fumigator for any part of the body: *e.g.*, for ulcer of the leg, as well as for the larynx.

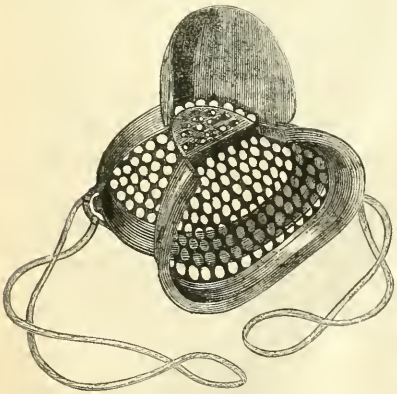
The apparatus has been made for Mr. Hamilton by Messrs. Krohne and Sesemann, of Duke Street, Manchester Square, and costs six shillings.

SAUNDBY ON ANTISEPTIC INHALATIONS IN PHTHISIS.

Dr. Saundby, Assistant-Physician to the General Hospital, Birmingham, finding that the use of antiseptic inhalations has proved useful in phthisis in his practice, and also in that of Dr. Sinclair Coghill, who has had special opportunities for estimating the value of treatment in this malady, has endeavoured to improve the necessary apparatus as far as possible. He has been using during the last year an inhalation respirator made for him by Mr. Best, instrument maker to the General Hospital, of Summer Lane, Birmingham, and which is figured in the accompanying woodcuts.



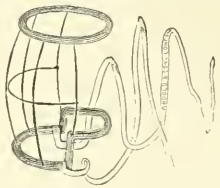
The naso-oral form, which Dr. Saundby has employed almost exclusively, is very well shaped, is light, comfortable, well ventilated, and worn by patients without complaint of inconvenience or fatigue. The antiseptic he has found most suitable is the oil of eucalyptus, in doses of five to ten drops poured on the flax twice daily.



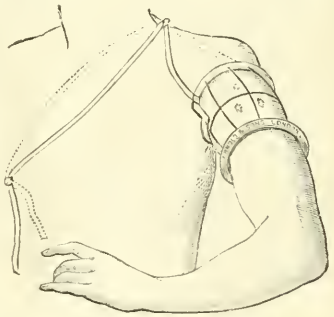
Dr. Saundby does not claim, nor does he think it can be rationally expected, to cure any cases by the use of these respirators; but many of his patients have found great relief from their use, mainly by checking purulent secretion and allaying cough.

DR. J. C. HOGAN'S VACCINATION SHIELD.

The Vaccination Shield, of which the annexed is an illustration, was devised by Dr. John C. Hogan, at the time when the recent small-pox epidemic in London was causing considerable uneasiness, to obviate the pain and inconvenience attended on the rubbing or adhesion of the sleeve to the vaccinated



part. This it satisfactorily accomplishes; and, moreover, as, from its construction, no pressure is made either above or below the part operated on, no hindrance to the free circulation of the blood occurs, an advantage which he thinks will recommend it for



use in cases of vaccination or adult revaccination. It is made in various sizes by Messrs. Arnold and Sons, West Smithfield, E.C.

TRICYCLES.

The use of tricycles is, we are glad to see, rapidly becoming more general amongst all classes. The rapid extension of the masses of bricks and mortar which constitute our enormous cities, makes it difficult to reach green fields or breathe fresh air by the use of the means of locomotion given to us by nature, but the happy possessor of a tricycle or bicycle, independent of distance, spins off on his iron horse, soon to reach green fields and pastures new. Indeed, we look upon the strings of tricycle and bicycle riders now to be met with on fine evenings and half-holidays, making their way to the suburbs of London, as a very healthy sign of the time. These iron horses give their riders the opportunity of spending time healthfully, and gaining physical and mental strength, when they would probably, but for the facilities afforded by this method of locomotion, be

spending their time in some crowded theatre or music-hall reeking with the fumes of tobacco.

In the country, also, tricycles and bicycles are frequently used for sending messages to the nearest town, railway-station, or neighbouring houses; as, even where horses are kept, it is found to be quicker to send a lad on a bicycle than to saddle a horse. In some districts they are coming into use for medical men and their assistants to go their rounds. They are beginning to be patronised by the country clergy; and for some time postmen in many rural districts have been provided with these machines, for hastening the delivery of their letters. The makers of bicycles and tricycles, finding that their wares are daily becoming more in demand, are naturally constantly adding improvements to ensure the desiderata which their productions should possess; such requisites being, in brief, rapid travelling, speed on dry roads, and lightness and facility of propulsion on soft ones, with power of climbing, and of turning in a small circle. Tricycles are now coming much into use, as they do not demand the same power of poising oneself accurately and of agility in mounting and dismounting as the bicycle requires. Most persons of ordinary activity can manage a tricycle, and attain the very satisfactory pace of ten miles an hour. A greater speed may be attained by a bicycle rider, but, as we have already pointed out, the difficulties of management, and the risk of an occasional fall, are more considerable, the third wheel of the tricycle giving greater steadiness to the machine, though at some sacrifice of speed. However, whether bicycle or tricycle be chosen, it is certain that the use of either will add materially to the health and enjoyment of the rider; and we shall be glad to know that, by the extension of bicycle and tricycle clubs, and other facilities for the purchase or hire of these machines, that every one who cannot afford to keep or hire a horse, yet gets his iron-horse exercise as a regular relaxation after business-hours or at holiday seasons. The Royal family, we learn with pleasure, have extended their patronage to this form of exercise; tricycles have been supplied to the order of Her Majesty and the Princess Beatrice, and the Prince of Wales has, at the recent Sportsman's Exhibition, chosen a tricycle similar to those used by the Stanley Club.

MISCELLANY.

DR. THEODOR SCHWANN, Professor of Physiology in the University of Liege, died at Cologne on January 11, at the age of 71. He was celebrated as the first exponent of the doctrine of cell-formation in animals.

A BUST of Dr. Protheroe Smith, the founder of the Hospital for Women, Soho Square, was recently presented to the institution by friends and patients, and was unveiled on the 15th ult. by Sir Rutherford Alcock, K.C.B., the Chairman of the Committee of Management, on being placed in position in the hall of the hospital. The work has been well executed by Mr. Belt.

FEMALE DOCTORS IN RUSSIA.—Twelve female doctors are now officially engaged in teaching medicine to women. Thirty are in the service of the Zemstvos, and forty others serve the hospitals. Twenty-five female doctors who took part in the military operations of 1877 have been decorated, by order of the Emperor, with the order of St. Stanislas of the third class. The number of female students is steadily increasing.

FEMALE PHYSICIANS IN AMERICA.—There are at the present moment nearly four hundred female physicians in active practice in twenty-six of the United States, the majority of them being settled in New York, Massachusetts, and Pennsylvania. These figures show a very rapid increase in the number of women practising medicine in the United States. A few years ago a lady doctor was more or less a *rara avis;* now there is scarcely a village in any one of the Eastern States which cannot boast of at least one such practitioner.

MR. STORRS TURNER, Secretary to the Society for the Suppression of the Opium Trade, writes to ask us to print an extract from a letter written by Dr. Kane, who was quoted in the LONDON MEDICAL RECORD for Jan. 15. The extract is as follows: 'Two smokers, one American and one Chinaman, have died here (New York), within ten days, from acute purulent peritonitis resulting from the bowel irritation and prolonged constipation incident to the practice of the vice. In the case of the American, Dr. Kane held a very full and satisfactory autopsy, the details of which he promises to Mr. Storrs Turner soon.

THE TEMPERATURE OF SICK ROOMS.—In the *Lancet*, September 1881, p. 390, an allusion to the well-known difficulty experienced during the illness of the late President General Garfield, to keep the room cool, it was suggested that the plan adopted, of placing blocks of ice about the chamber, afforded the readiest mode of securing the desired result. At p. 574, this suggestion is criticised, the writer showing that the blocks of ice, thus placed, were exposed to the lowest and therefore coolest stratum of air, where also but little movement of the air took place; whilst, by means of the Chemical Lung or Punkah, lately exhibited at the International Exhibition, charged with iced water, pure or medicated, waving to and fro from the ceiling, the temperature of the hottest room, with an atmosphere of the foulest kind, could be most rapidly cooled and purified.

THE MUSCULAR FORCE OF A CROCODILE'S JAW.—An experiment has been lately made in Paris by Drs. Regnard and Blanchard on the measurement of the power exerted by the masseter muscle in a crocodile. Ten live crocodiles of the species *C. galeatus* or *siamensis*, that had been sent in large cases from Saigon to M. Paul Bert, afforded the opportunity for such experiments. Some of these animals were as much as 10 ft. in length, and weighed about 154 lbs. The difficulty of managing such creatures in the laboratory was, of course, considerable. The crocodile was fixed with ropes on a heavy table; the lower jaw kept in contact with the table by a cord, while the upper was raised by means of a cord attached at the extremity and passing up to a beam overhead. A dynamometer was inserted in this cord, and was affected when the animal was stimulated with an electric current. In this way, a crocodile of about 120 lbs. weight gave an indication of 308 lbs. (140 kilogrammes). The application of the cord at the end of the snout was necessary but unfavourable, seeing the application of the force is thus at the end of a long lever, and there is at least five times more space between this point and the insertion of the masseter muscle than between the latter and the joint of the jaw—the fulcrum. Hence the masseter really produces a force five times that indicated by the dynamometer, or about 1,540 lbs. (700 kilogrammes). This extraordinary force, it should be remembered, was that of an animal somewhat weakened and at a low temperature. The force (of about 308 lbs.) is really applied at the end of four large teeth that project beyond all the others, and, considering the surface here represented, the authors estimate the pressure, while the bite is executed by the extremity of those teeth, at nearly 400 atmospheres. Making similar experiments with an ordinary sporting dog, they obtained in the dynamometer a pressure of about 72 lbs.; while the effect at the insertion of the masseter was about 360 lbs. The pressure at the point of the canine teeth would be about 100 atmospheres. It is calculated that the crocodile is about one-third stronger than a dog of the same weight would be.

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AMORPHOUS UNCRYSTALLIZABLE QUININE, with other constituents of PERUVIAN BARK, CINCHONIDIA, QUINIDIA, and CINCHONIA, with some Colouring Matter, prescribed in the same manner and dose as Quinine.

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Stanley House, Blackstock Road, Finsbury Park, N., February 1881.

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Messrs. W. R. WARNER & Co.

8, Cumberland Terrace, Finsbury Park, N., 25th February 1881.

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A DELICIOUS BEVERAGE AND TONIC,
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LIEBIG'S EXTRACT OF MEAT AND MALT WINE (COLEMAN'S).
TESTIMONIALS.
Thorpe Hamlet, Norwich, February 23rd, 1881.

SIR,—A short time since I was induced by the novelty of the title to send for a bottle of your Liebig's Extract of Meat and Malt Wine. I was perfectly acquainted with the value of the *Extractum Carnis*, and not quite a stranger to the invigorating and fortifying properties of Malt Wine, and, therefore, felt a natural curiosity to test them when combined. Men who work hard, as I do, not muscular hard work, but that which is quite as exhausting, viz., brain work, very often experience the need of, and have sometimes an almost irresistible craving for, a 'pick me up'; and very often the panacea for a time for lassitude, and that state of mind which renders work irksome, are alcoholic stimulants, the use of which must sooner or later end disastrously. The man who can furnish a remedy sure, certain, and harmless, for the lassitude which follows constant brain work, is a benefactor of his species, and may be said to have added many years of usefulness to the lives of useful men. Your extract, if a success, and when more generally known, will be used by all toilers of the mind.

Yours faithfully, O. D. RAY.

LIEBIG'S EXTRACT OF MEAT AND MALT WINE (COLEMAN'S).
Queen's Crescent, Haverstock Hill, March 5th, 1881.

DEAR SIR,—Some time since, being greatly fatigued with over-work and long hours at business, my health (being naturally delicate) became very indifferent. I lost all energy, strength, and appetite, and was so weak as to be scarcely able to walk. As you are aware, I sent for a dozen of your Extract of Meat and Malt Wine, which, in a few days, pulled me up marvellously. Three or four glasses of it daily have quite altered and restored me to better health than ever, without the assistance of a doctor'. I am now giving it to my son twelve years of age, whom we have always thought consumptive, and from a puny ailing boy he seems to be fast growing into a strong healthy lad. Enclosed you have a cheque. Please send me two dozen of the 'Extract'. With thanks for your prompt attention to my last.

I am, Sir, yours truly, GEORGE A. TYLER.

LIEBIG'S EXTRACT OF MEAT AND MALT WINE (COLEMAN'S).
Grampound, February 25th, 1881.

Mrs. Coulson thanks Mr. Coleman for the book and stamps, and she has no doubt but that 'the tonic' is a good one. Mrs. C. encloses twelve stamps for basket.

LIEBIG'S EXTRACT OF MEAT AND MALT WINE (COLEMAN'S).
Vicarage, Kingsbridge, Devon, January 25th, 1881.

DEAR SIR,—We are ten miles from the railway, and have been snowed up, consequently the wine has only just arrived. I enclose a cheque for £2 11s. 6d. I like the wine, and will recommend it.

Mr. Coleman, Norwich. Yours faithfully, A. N. KINGSTON.

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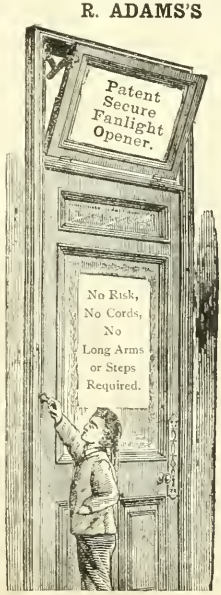

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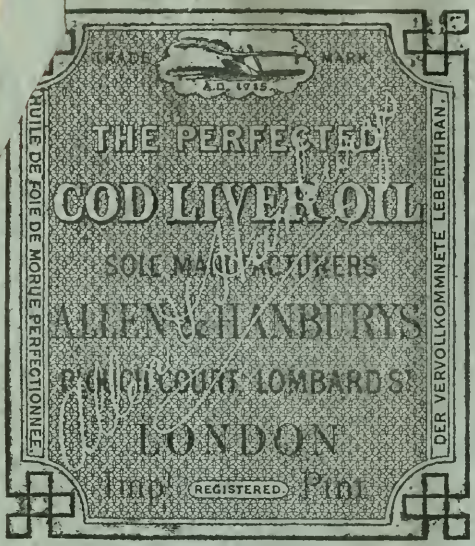

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